

2017


YOUTH CAMP


NEW DIRECTORS


TRAINING PACKET


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	<h2 style="text-align: center;">Certification for Youth Camps</h2> <h3 style="text-align: center;">2017</h3>	
	<p style="text-align: center;">Department of Health and Mental Hygiene Environmental Health Bureau</p>	
	<p style="text-align: center;">Center for Healthy Homes and Community Services 6 Saint Paul St, Suite 1301 Baltimore, MD 21202-1608</p>	
	<p style="text-align: center;">Phone 410-767-8417 Fax 410-333-8926</p>	
	<p style="text-align: right;"><small>Prevention and Health Promotion Administration 2017</small></p>	

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	<p>Allegany + Anne Arundel + Calvert Carroll + Charles + Frederick Garrett + Howard + Montgomery Prince George's + St. Mary's Washington</p> <p>Baltimore City + Baltimore + Caroline Cecil + Dorchester + Harford + Kent Queen Anne's + Somerset + Talbot Wicomico + Worcester</p> <p style="text-align: right;"><small>Prevention and Health Promotion Administration 2017</small></p>	

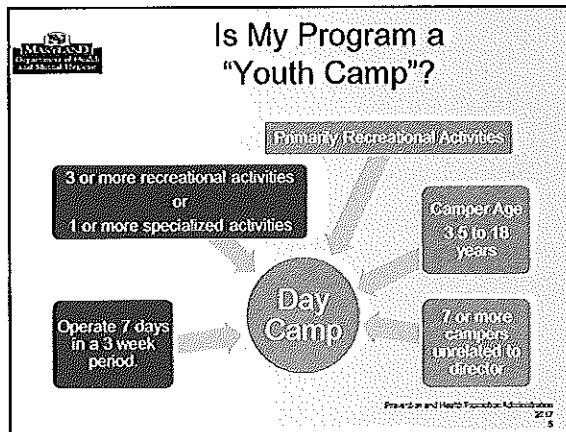
	<h2 style="text-align: center;">Mission Statement</h2>
	<p>MISSION</p> <p>• The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.</p>
	<p>VISION</p> <p>• The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.</p>
	<p style="text-align: right;"><small>Prevention and Health Promotion Administration 2017</small></p>

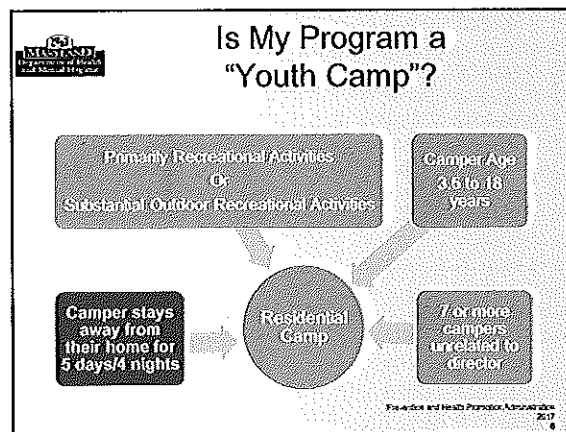


Legal Authority/Regulation

- Law: Youth Camp Act:
Health General Title 14 Subtitle 4
- Regulation: COMAR 10.16.06
 - Updated in 2016
- Regulation: COMAR 10.16.07
 - Created in 2016
- Regulation: COMAR 10.01.17
 - Update in 2016

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What Is **NOT** a Youth Camp?

- A licensed child care center
- A family day care home
- A program operating before or after a daily school session
- A competitive activity sponsored by a sports league
- An instructional program of 2 hrs. or less in a specialized activity

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What Is **NOT** a Youth Camp?

- A summer school program taught by certified teacher and offering credit
- A program or activity where parents/guardians are present for duration, participate, and oversee activities of the child

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What Is **NOT** a Youth Camp?

- A program enrolling children under the age of 3.5 years old cannot be licensed as a youth camp.
 - The operator should consult with Child Care Administration to see if a child care license is required.

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New Application

- *New Youth Camp Application
 - *Print from Youth Camp website
<http://chea.dhs.mass.gov/DOHPP/CHS/Shared%20Documents/App%20for%20YouthCamp.pdf>
 - Fill out completely, accurately, attach all required supporting documents, & fee
- *Renewal Applications
 - *Renewal packages are sent to operator
 - *"Good Standing" - Pay reduced fee
- *Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

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Fee Chart

For the Youth Camp and Youth Center
For the Youth Center and Youth Center
For the Youth Center and Youth Center

Category	Fee	Fee	Fee
Application	\$100	\$100	\$100
Renewal	\$100	\$100	\$100
Annual Report	\$100	\$100	\$100
Self-Assessment	\$100	\$100	\$100

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Renewal Application

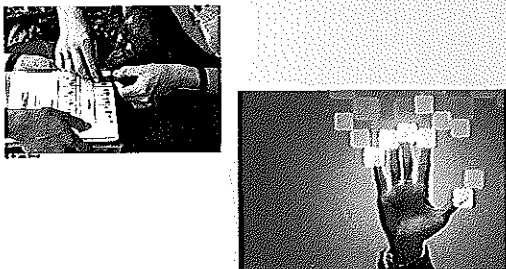
- *Renewal Applications
 - *Renewal packages are sent to operator
 - *"Good Standing" - Pay reduced fee
 - *Application submitted on time
 - *Annual Report submitted on time
 - *All fees paid
 - *No Critical Violations for 2 years
 - *Self-Assessment submitted on time
- *Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

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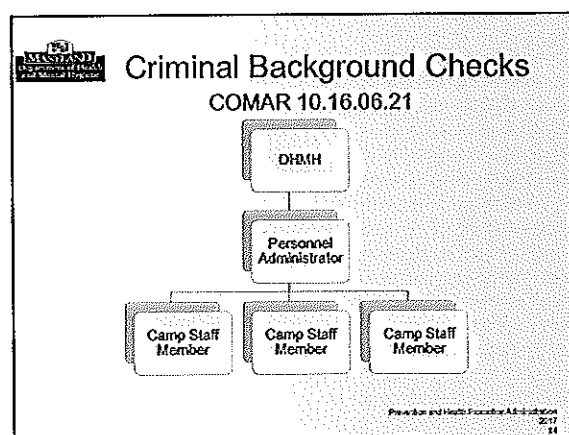
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Criminal Background Checks

COMAR 10.16.06.21

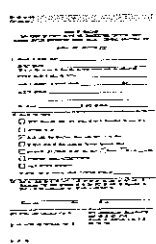


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Authorization Number



- Camp applies for Authorization Number through CJIS
- Results are sent to contact person
- Email notification
- View/print results from secure web site

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Criminal Background Checks

Maryland

And

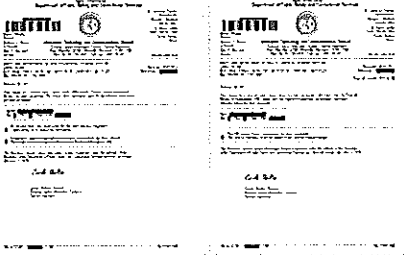
FBI

- Must have completed MD & FBI check for all required employees
- Copy of results must be addressed to employer, not the employee

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MARYLAND
Department of Health
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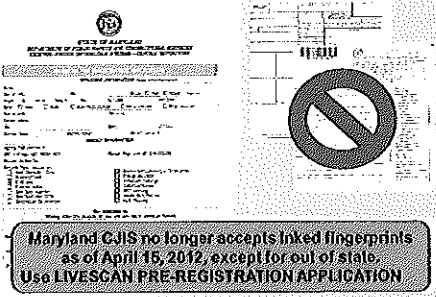
Criminal Background Checks



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MD
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Department of Health
and Mental Hygiene

Fingerprints




Maryland CCHS no longer accepts inked fingerprints as of April 15, 2012, except for out of state. Use LIVESCAN PRE-REGISTRATION APPLICATION

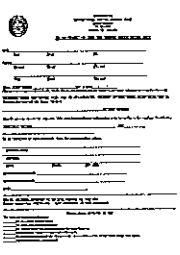
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 **Personnel Administrator**

- ◊ DHMH must have the personnel administrator's criminal background results from CJIS
- ◊ Use DHMH Authorization Number: 9400019171
- ◊ **DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS**


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 **365 Day Request**




- ◊ Use for individuals who were fingerprinted for child care within last year
- ◊ Does not require fingerprints
- ◊ No charge

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 **Background Clearance from Child Protective Services**

- ◊ All employees must complete CPS Release of Information Form (DHR/SSA 1279).
- ◊ Personnel Administrator should use the sample form provided which includes the contact information for DHMH-CHCS.


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Reviewing Background Checks and Clearances

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.
- No hits for something in Regulation .21E.
- If hit for something in Regulation .21F must review accordingly.


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Procedures




- Emergency Procedures
Regulation 10.16.06.34
- MD and FBI background checks
Regulations 10.16.06.52 and 53
- Background Clearance Procedures
Regulation 10.16.06.54
- Continuing Education
Regulations 10.16.06.47, through 52
- Child Abuse Reporting and Procedures
Regulation 10.16.06.55


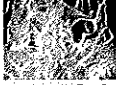
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Emergency Procedures

- Regulation 10.16.06.34
– Natural disasters and severe weather

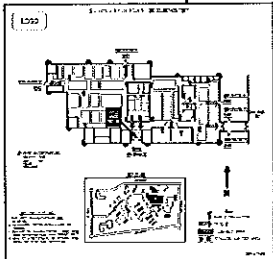



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Emergency Procedures

-Evacuation plan




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Emergency Procedures

-Missing campers

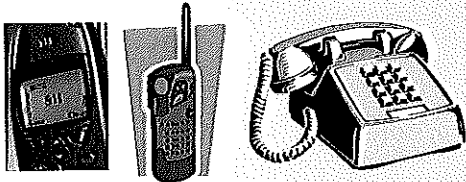


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Emergency Procedures

-911




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and Social Services

Emergency Procedures

–Transportation for Evacuation

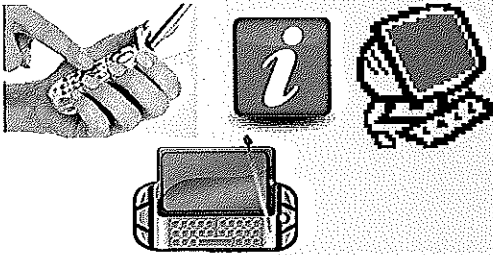


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Emergency Procedures

–Notify parents




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Emergency Procedures

–Ensure camper safety



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Trip and Transportation

- Regulations 10.16.06.52 and .53
- Written Safety Plans for:
 - Field trips (See Handout)
 - Transportation (See Handout)
 - Safety Seats for Younger Children
- Written parental authorization
- Rules
- Supervision


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Specialized Activities Regulation .47 - .52

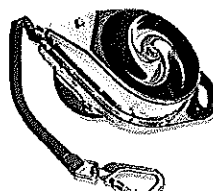
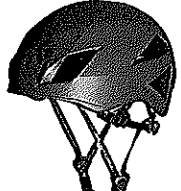
- All Specialized Activities
 - Director Present
 - Safety Plan Developed and Implemented
 - Staff Training
 - Staff Ratio (1 staff to 10 campers)
- Swimming
 - Swim ability test
 - Safety system to quickly account for campers
 - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding

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Specialized Activities Change to Regulation .51

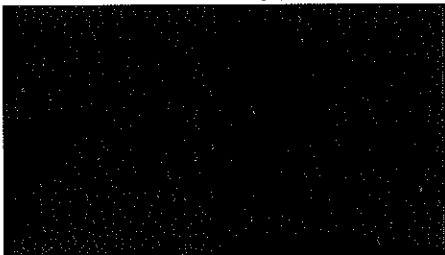
A helmet is required for rock climbing or high ropes activities, except when an auto-belay system is utilized.

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Supervision		
Campers	Required Number of Adults and Assistant Counselors	
	Adults	Assistant Counselors or Adults
3½ to 5 years old		
1 to 8	1	0
9 to 16	1	1
17 to 24	1	2
6 to 10 years old		
1 to 15	1	0
16 to 30	1	2
Or	2	0
11 years old or older		
1 to 15	1	0
16 to 30	1	2
Or	2	0
31 to 40	2	2
Or	3	0

**Child Abuse
Prevention and Reporting
Mandated Reporters**



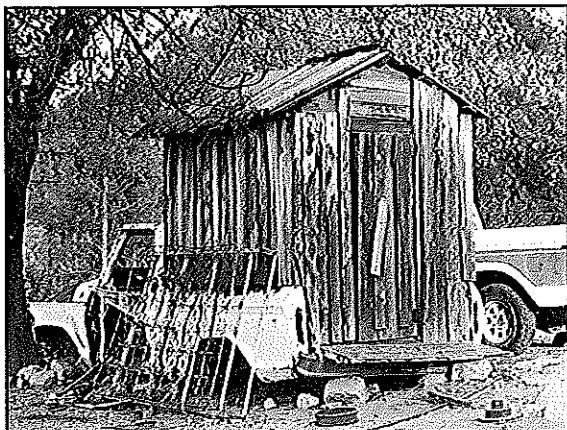
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**Child Abuse
Prevention and Reporting**

Regulation 10.16.06.35

- Develop and implement child abuse prevention and reporting plan **see handout**
- Provide training to staff members on the prevention and reporting plan annually
- Keep sign-in sheet for training on file
- Keep a copy of the local DSS numbers on file

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Facilities

Type of Facility	Day	Residential
1 Toilet per	35 campers	15 campers
1 Hand Washing Unit per	35 campers	25 campers
1 Showerhead per	N/A	15 campers
1 Bed, Cot or Bunk per	N/A	1 camper

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Facilities




- Garbage removal, COMAR 10.16.06.43
 - Durable containers in good repair
 - Collected as necessary to prevent overflow
- Disposed of legally
- Outside containers have:
 - Tight-fitting Lids
 - Are leak-proof, fly-proof, and rodent-proof

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Facilities

- Insect and rodent control, COMAR 10.16.06.44
 - Minimize entry
 - Eliminate harborage




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Documentation for Private Building

- Building
 - Use and Occupancy Permit
 - Or
 - Master Plumber and Master Electrician Letters
- Water and Sewage
 - Public Water and Sewer
 - Or
 - Local Health Approval Form
- Fire Marshal Inspection
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD


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Documentation for School/Government Building

- Building Safety Form
 - Covers:
 - Water
 - Sewage Disposal
 - Plumbing
 - Electrical
 - Fire
 - Building/Zoning
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD

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Health Program

Health Supervisor

COMAR 10.16.07.04

- Doctor
- Nurse
- Certified Nurse Practitioner
- Duties
 - Review & Approve Health Program Annually
 - Oversee or Delegate Medication Administration
 - Oversee Health Treatment Area
 - Review Camper Health Forms

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Health Program

CPR/First Aid

COMAR 10.16.07.04

- Minimum of 2 Adults
 - Certification Issued by National Organization
- On Duty at All Times
 - From 1st camper arrival to last camper pick up
- Field Trips
 - One with trip and one at camp if campers stay behind

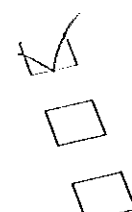

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Health Program

Written Health Program

COMAR 10.16.07.03

Refer to list of questions
provided in your packet.

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and Human Services

Health Program

Medications

COMAR 10.16.07.14

- Covers Prescription and Nonprescription Medications
- Delegation ability varies depending on credentials of Health Supervisor
- Self-administration vs. Staff Administration
- Prescriptive Order for All Medication – DHMH form (may be used at multiple camps for one season)
- Parental Consent Documented
- Standing Orders
- Sunscreen, see January 25, 2017 memo

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and Human Services

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- Applicant = Someone that:
 - 1) Operates a youth camp
 - 2) Is at least 18 years old
 - 3) Has successfully completed an emergency epinephrine training program approved by the department.

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and Human Services


Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- The applicant may apply to the Department for a Certificate for Emergency Epinephrine by submitting a written policy that includes:
 - 1) Designation of agents
 - 2) The name of the approved emergency epinephrine educational training program
 - 3) Procedures to:
 - a) Store the epi pen
 - b) Notify parents it is available
 - c) Maintain epi pen in secure manner
 - d) Report use of epi pen according to .06
 - e) Train certificate holder and agent annually
 - f) Keep training docs. for 3 years


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 **Health Program**
(Optional) Emergency Epinephrine
COMAR 10.16.07.15

•An emergency epinephrine educational training program shall include:


- 1) The signs and symptoms of anaphylaxis
- 2) Use of an emergency auto-injectable epinephrine pen
- 3) Follow-up procedures with a parent or guardian after an emergency auto-injectable epinephrine is administered
- 4) A skills demonstration
- 5) A written examination

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 **Health Program**
(Optional) Emergency Epinephrine
COMAR 10.16.07.15

•An individual teaching an emergency epinephrine educational training program shall be licensed as a physician, a registered nurse, or a certified nurse practitioner.


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 **Health Program**
(Optional) Emergency Epinephrine
COMAR 10.16.07.15

•A certificate for emergency epinephrine holder may:

- 1) On presentation of a certificate for emergency epinephrine, receive from any physician licensed to practice medicine in the State a prescription for auto-injectable epinephrine; and
- 2) Possess and store prescribed auto-injectable epinephrine

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Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

•In an emergency, a certificate for emergency epinephrine holder or agent may administer auto-injectable epinephrine to an individual who is experiencing or believed in good faith by the certificate holder or agent to be experiencing anaphylaxis.

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Health Program

Treatment Area

COMAR 10.16.07.13

Day Camp


Antibiotic
Coverage

Pain
and
Care

First Aid
and First
Washing

Cognitive
Assessment

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Health Program

Treatment Area

COMAR 10.16.07.13

Residential Camp


Antibiotic
Coverage

Pain
and
Care

First Aid
and First
Washing

Cognitive
Assessment

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Health Program

Health Records

COMAR 10.66.07.08

Client Name _____

No. Records Available in Custody _____

Signature of Client _____ **Date** _____

Signature of Health Worker _____ **Date** _____

Job Number _____

Health Worker's Name _____

1. Date of last physical examination _____

2. Date of last chest X-ray _____

3. Date of last sputum examination _____

4. Date of last blood pressure reading _____

5. Date of last ECG _____

6. Date of last pulmonary function test _____

7. Date of last skin test _____

8. Date of last tuberculin test _____

9. Date of last chest X-ray _____

10. Date of last sputum examination _____

11. Date of last blood pressure reading _____

12. Date of last ECG _____

13. Date of last pulmonary function test _____

14. Date of last skin test _____

15. Date of last tuberculin test _____

RECOMMENDATIONS

1. Smoking status _____

2. Alcohol consumption _____

3. Diet _____


4. Exercise _____

5. Other _____

Signature of Health Worker _____ **Date** _____

Signature of Client _____ **Date** _____



[illegible]



Health Program

Health Log



COMAR 10.16.07.05

See Sample Health Log


Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Spiral Book Must Have Sequentially Numbered Pages

Parental and Health Promotive Administrative
2019

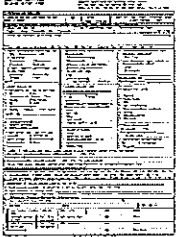
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Health Program

Incident Report

COMAR 10.16.07.06 and .07



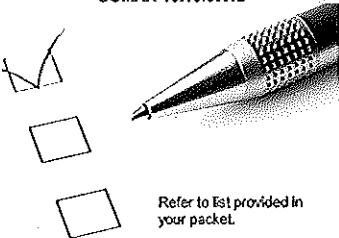
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Health Program

Acute Illness & Communicable Disease

COMAR 10.16.07.12



Refer to ESI provided in your packet.

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Staff Training and Certification

- Training
 - Document staff training for the following:
 - Health Program
 - Including Medication Administration
 - Emergency Plan
 - Trip Safety Plan
 - Transportation Safety Plan
 - Specialized Activities Safety Plans
 - Child Abuse Prevention and Reporting
- CPR and First Aid certification
 - Document current CPR/first aid
 - Ensure that at least 2 adults with CPR/FA are on duty during camp

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Submitting Required Reports

- ◊ COMAR 10.16.06.06 and COMAR 10.16.07.06
- ◊ Annual Report must be sent to Center for Healthy Homes and Community Services within 4 weeks of camp ending along with any required injury/illness reports.

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Submitting Required Reports

- ◊ Camps will be able to submit Annual Report online.

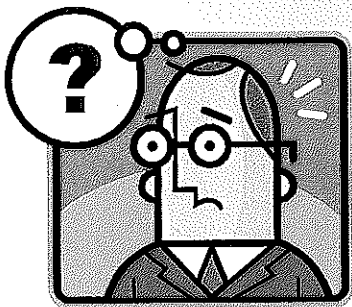
<https://envhlthlicensing.dhmf.maryland.gov/Account/Login>

- ◊ DHMH is working on finalizing the Incident Report for online submission as well.

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Questions



Prevention and Health Promotion Administration
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**IS MY
PROGRAM A
YOUTH CAMP?**

Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camps

Day Program Evaluation

Program Name		Physical Address		
Contact Name		City	State	Zipcode
Phone #		Email Address		
Evaluation Questions				
Question #	Question			1=YES 0=NO
1	Does the program serve 7 or more children unrelated to the youth camp operator ¹ {COMAR 10.16.06.02B(45)(a)(i)}? Number of Children Served: _____			
2	Does the program serve children who range in age from 3 1/2 to 18 years old {COMAR 10.16.06.02B(9)}? Age Range of Children Served: _____			
3	Does the program conduct 3 or more recreational activities ² or any 1 specialized activity ³ {COMAR 10.16.06.02B(15)(c)}? Recreational Activities: _____ Specialized Activities: _____			
4	Does the program operate for at least 7 calendar days during a 3-week period {COMAR 10.16.06.02B(15)(b)}? Dates of Operation: _____ Number of Days in a 3-Week Period: _____			
5	Does the program conduct primarily recreational activities or a substantial outdoor recreational component ⁴ {COMAR 10.16.06.02B(45)(a)(ii)}?			
TOTAL				
Is the program required to be licensed as a youth camp?				
If total is 5, then		If total is less than 5, then		
YES		NO		

Evaluator's Signature: _____ Date: _____

Footnotes

- [1] COMAR 10.16.06.02B (28) "Operator" means a person who owns, supervises, controls, conducts, or manages a youth camp.
- [2] COMAR 10.16.06.02B (34) Recreational Activity.
(a) "Recreational activity" means a pleasurable, interesting, and entertaining activity.
(b) "Recreational activity" includes, but is not limited to:
(i) Structured or unstructured play;
(ii) A nature walk;
(iii) A field trip;
(iv) A sports activity;
(v) A game;
(vi) A hobby;
(vii) Music;
(viii) Drama;
(ix) Dance;
(x) Art;
(xi) A craft;
(xii) Except if for credit and taught by a certified teacher, a subject matter enrichment program;
(xiii) A specialized activity; or
(xiv) Instruction or skill development in an activity listed in §B(34)(b)(i)—(xiii) and (39) of this regulation.
- [3] COMAR 10.16.06.02B (39) "Specialized activity" means:
(a) An adventure camp activity or program;
(b) An aquatic program;
(c) Archery;
(d) Artistic gymnastics;
(e) Firearms control;
(f) Hang gliding;
(g) High ropes;
(h) Horseback riding;
(i) Motorized vehicle activities;
(j) Rappelling;
(k) Riflery;
(l) Road cycling;
(m) Rock climbing;
(n) Skiing; and
(o) Spelunking.
- [4] COMAR 10.16.06.02B (40) "Substantial outdoor recreational component" means that 25 percent or more of a camper's time at camp is spent in outside recreational activities.

Evaluator's Signature: _____ Date: _____

Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camps

Overnight Program Evaluation

Program Name		Physical Address		
Contact Name		City	State	Zipcode
Phone #		Email Address		
Evaluation Questions				
Question #	Question			1=YES 0=NO
1	Does the program serve 7 or more children unrelated to the youth camp operator ¹ {COMAR 10.16.06.02B(45)(a)(i)}? Number of Children Served: _____			
2	Does the program serve children who range in age from 3 1/2 to 18 years old {COMAR 10.16.06.02B(9)}? Age Range of Children Served: _____			
3	During the program do children live apart from their relatives, parents or legal guardians for at least 5 consecutive days or 4 nights {COMAR 10.16.06.02B(35)}? Dates of Operation: _____ Number of Days Apart: _____ Number of Night Apart: _____			
4	Does the program conduct primarily recreational activities ² or have a substantial outdoor recreational component ³ {COMAR 10.16.06.02B(45)(a)(ii)}?			
TOTAL				
Is the program required to be licensed as a youth camp?				
If total is 4, then		If total is less than 4, then		
YES		NO		

Evaluator's Signature: _____ Date: _____

Footnotes

- [1] COMAR 10.16.06.02B (28) "Operator" means a person who owns, supervises, controls, conducts, or manages a youth camp.
- [2] COMAR 10.16.06.02B (34) Recreational Activity.
 (a) "Recreational activity" means a pleasurable, interesting, and entertaining activity.
 (b) "Recreational activity" includes, but is not limited to:
 (i) Structured or unstructured play;
 (ii) A nature walk;
 (iii) A field trip;
 (iv) A sports activity;
 (v) A game;
 (vi) A hobby;
 (vii) Music;
 (viii) Drama;
 (ix) Dance;
 (x) Art;
 (xi) A craft;
 (xii) Except if for credit and taught by a certified teacher, a subject matter enrichment program;
 (xiii) A specialized activity; or
 (xiv) Instruction or skill development in an activity listed in §B(34)(b)(i)—(xiii) and (39) of this regulation.
- [3] COMAR 10.16.06.02B (40) "Substantial outdoor recreational component" means that 25 percent or more of a camper's time at camp is spent in outside recreational activities.

YOUTH CAMP APPLICATION

NEW YOUTH CAMP APPLICATION FOR A YOUTH CAMP THAT WAS NOT ISSUED A CERTIFICATE OR LETTER OF COMPLIANCE IN THE PREVIOUS YEAR

Maryland Department of Health and Mental Hygiene (DHMH)
Environmental Health Bureau
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore, Maryland 21202-1608
Phone 410-767-8417 Fax 410-333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

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*** FOR OFFICE USE ONLY ***			
DATE RECEIVED	AMOUNT RECEIVED	CHECK NUMBER	IDENTIFICATION NUMBER
<p>INSTRUCTIONS: Maryland youth camp regulations (COMAR 10.16.08) require a youth camp operator to obtain a certificate or letter of compliance from the Department of Health and Mental Hygiene (DHMH) before the camp opens. Before a certificate or letter of compliance is issued, DHMH must determine substantial compliance with the regulations.</p> <ul style="list-style-type: none"> ▶ Complete parts: A. through K. Retain a copy of the application for your records. ▶ Enclose the initial application fee. Make check or money order payable to the Maryland Department of Health and Mental Hygiene. ▶ Mail the completed original application, fee and the required compliance documentation noted throughout the application to DHMH at least 60 days before the camp opens. Do not fax the application. ▶ If you operate multiple camps at separate sites, submit a separate application, fee and compliance documentation for each camp. ▶ If you have questions or require assistance, please call DHMH, Center for Healthy Homes and Community Services at the above numbers. 			
A. OWNER/BUSINESS INFORMATION			
1. BUSINESS NAME			
2. BUSINESS TYPE:		3. FEIN	
<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> OTHER:		<input type="checkbox"/> CO-OWNERSHIP <input type="checkbox"/> CORPORATION	
4. BUSINESS ADDRESS			
5. CITY, STATE, ZIP		6. COUNTRY	
		<input type="checkbox"/> USA <input type="checkbox"/> OTHER:	
7. BUSINESS CONTACT NAME			
8. BUSINESS PHONE	9. OTHER PHONE	10. FAX	
11. BUSINESS CONTACT EMAIL			
B. YOUTH CAMP INFORMATION			
1. CAMP NAME			
2. CAMP PHYSICAL ADDRESS			
3. CITY, STATE, ZIP		4. MARYLAND COUNTY	
5. CAMP DIRECTOR'S NAME			
6. CAMP DIRECTOR'S PHONE	7. EMERGENCY PHONE	8. FAX	
9. CAMP DIRECTOR'S EMAIL			
10. CAMP MAIL ADDRESS: <input type="checkbox"/> SAME AS CAMP PHYSICAL ADDRESS ABOVE <input type="checkbox"/> SAME AS BUSINESS ADDRESS ABOVE			
ATTN (PERSON'S FIRST AND LAST NAME)		BUSINESS NAME	
ADDRESS			
CITY, STATE, ZIP		COUNTRY	
		<input type="checkbox"/> USA <input type="checkbox"/> OTHER:	
11. CERTIFICATION TYPE (Check one) <input type="checkbox"/> Certificate <input type="checkbox"/> Letter of Compliance -For bona fide religious organizations only.			
12. CAMP TYPE (Check one)			
<input type="checkbox"/> Day Camp <input type="checkbox"/> Residential Camp <input type="checkbox"/> Day and Residential Camp <input type="checkbox"/> Trip Camp <input type="checkbox"/> Travel Camp			

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C. CURRENT CAMP PROGRAM INFORMATION. Attach current camp brochure.		
1. CAMP OPENING DATE	2. CAMP CLOSING DATE	3. DATE(S) CLOSED FOR BUSINESS
Attach fee with completed application. Make check payable to the Department of Health and Mental Hygiene		
4. FEE ENCLOSED		
INITIAL APPLICATION FEE FOR DAY CAMP \$190	INITIAL APPLICATION FEE FOR RESIDENTIAL CAMP, DAY AND RESIDENTIAL CAMP, TRIP CAMP, OR TRAVEL CAMP \$500	
Payment of Fee Difference Owed. (1) The Department shall: (a) Calculate a fee difference, that is, the difference between the fee paid at the time of application and the fee owed, based on information reported by a camp operator in the annual report for the past calendar year as required by Regulation .06 of COMAR 10.16.06 and the fees found in COMAR 10.01.17; and (b) Notify a camp operator of any fee owed to the Department. (2) Within 2 weeks following receipt of the notice from the Department, the camp operator shall pay the fee owed to the Department.		
FEE CHART FOR DAY CAMP	FEE CHART FOR RESIDENTIAL CAMP, DAY AND RESIDENTIAL CAMP, TRIP CAMP, OR TRAVEL CAMP	
1 to 500 CAMPER DAYS : \$190 501 to 2,000 CAMPER DAYS: \$500 2,001 to 5,000 CAMPER DAYS: \$665 5,001 or more CAMPER DAYS: \$855	1 to 700 CAMPER DAYS : \$500 701 to 5,000 CAMPER DAYS: \$1,000 5,001 to 16,000 CAMPER DAYS: \$1,500 16,001 or more CAMPER DAYS: \$2,000	
5. IS YOUR CAMP CURRENTLY ACCREDITED BY (Check One, If Applicable) <div style="float: right;"> <input type="checkbox"/> American Camp Association (ACA) <input type="checkbox"/> Boy Scouts of America (BSA) </div>		
Attach a copy of current certification from the accrediting organization, no fee is required.		
D. YOUTH CAMP FACILITY INFORMATION		
1. ARE YOU OPERATING A CHILDCARE CENTER AT THIS SITE? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>Attach a copy of license.</i>		
2. DID YOU NOTIFY THE CHILD CARE LICENSING OFFICE ABOUT YOUR INTENT TO OPERATE A YOUTH CAMP AT THIS SITE? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>Attach documentation of the notification.</i>		
3. BUILDING(S) TYPE (Check all that apply.) <input type="checkbox"/> School (Public or Private) or Government Owned Building: <i>Attach completed Building Safety form.</i> <input type="checkbox"/> Privately Owned Building or Property <i>Attach a copy of a current Fire Safety Inspection (COMAR 10.16.06.42) from the State or Local Fire Marshal's Office.</i> <i>Attach the Use & Occupancy permit. If no Use & Occupancy permit, attach certification from a master electrician and a master plumber stating the building meets code and attach documentation of zoning approval.</i> <input type="checkbox"/> Outdoor Pavilion or No Buildings. <input type="checkbox"/> Other, Specify Type: _____ <i>Contact this Office for required compliance documentation.</i>		
4. WATER SUPPLY -- COMAR 10.16.06.36 <input type="checkbox"/> Public: <i>Specify the water company from your water bill:</i> _____ <input type="checkbox"/> On-Site Well: <i>Attach completed Local Health Approval form.</i>		
5. SEWAGE DISPOSAL -- COMAR 10.16.06.37 <input type="checkbox"/> Public: <i>Specify the sewer service company:</i> _____ <input type="checkbox"/> On-Site Sewage Disposal System: <i>Attach completed Local Health Approval form.</i>		
6. BATHROOM FACILITIES. - COMAR 10.1606.38 and .39 (Check all that apply.) <div style="display: flex; justify-content: space-between;"> <div> Male <input type="checkbox"/> Toilets, # _____ Female <input type="checkbox"/> Toilets, # _____ <input type="checkbox"/> Portable Toilets <input type="checkbox"/> Male, # _____ <input type="checkbox"/> Privies <input type="checkbox"/> Male, # _____ </div> <div> <input type="checkbox"/> Handsinks, # _____ <input type="checkbox"/> Handsinks, # _____ <input type="checkbox"/> Female # _____ <i>Attach completed Local Health Approval form.</i> <input type="checkbox"/> Female # _____ <i>Attach completed Local Health Approval form.</i> </div> <div> <input type="checkbox"/> Showers, # _____ <input type="checkbox"/> Showers, # _____ </div> <div> <input type="checkbox"/> Urinals, # _____ </div> </div>		

7. CAMP FACILITIES - **COMAR 10.16.06.40 and .41** (Check all that apply.)

☐ Sleeping Facilities ☐ Tents ☐ Cabins ☐ Other, specify: _____

8. FOOD SERVICE - **COMAR 10.16.06.42** (Check all that apply.)

☐ Meals Prepared On-Site: **Attach copy of food permit.**
☐ Lunches Brought From Home: ☐ Refrigeration provided ☐ Notice to send non-perishable food given to parents
☐ Summer Lunch Program: **Attach verification of acceptance from certifying organization.**

9. PRIMITIVE CAMP A youth camp where permanent facilities for water supply and sewage disposal systems, food service facilities, sleeping areas, bathing facilities, and hand washing facilities are not available. (If your camp or any portion of your camp is a primitive camp, check all that apply.)

☐ No Permanent Facility for Water Supply System: **Attach the camp's written procedure for water filtration and disinfection (COMAR 10.16.06.36).**
☐ No Permanent Facility for Sewage Disposal System: **Attach the camp's written procedure for sewage disposal (COMAR 10.16.06.37).**
☐ No Permanent Facility for Food Service: **Attach the camp's written food preparation and handling plan (COMAR 10.16.06.42).**
☐ No Permanent Facility for Sleeping Areas: **Attach description of the camp's sleeping provisions (COMAR 10.16.06.40 and .41).**
☐ No Permanent Facilities for Bathing or Hand Washing: **Attach the camp's written bathing or hand washing procedures (COMAR 10.16.06.38 and .39).**

E. HEALTH PROGRAM INFORMATION

1. HEALTH SUPERVISOR'S NAME

PHONE

2. HEALTH SUPERVISOR'S TITLE (Check one)

MD LICENSE #

☐ Physician ☐ Registered Nurse ☐ Certified Nurse Practitioner

3. DO 50% OR MORE OF THE CAMPERS HAVE IDENTIFIED MEDICAL PROBLEMS?

☐ NO ☐ YES

4. THE HEALTH SUPERVISOR IS: **COMAR 10.16.07.04** (Check one)

☐ Available for consultation at all times when campers are present.
☐ On-site at all times when campers are present. *Required when 50% or more of the campers have identified medical problems.*

5. WRITTEN HEALTH PROGRAM **Attach a copy of the camp's health program that includes the health supervisor's annual approval. (COMAR 10.16.07.03 and .14)**6. CAMPER HEALTH RECORD **Attach example of the camp's camper health record form. (COMAR 10.16.07.08)**7. STAFF HEALTH RECORD **Attach example of the camp's staff member/volunteer health record form. (COMAR 10.16.07.09)**

8. HEALTH LOG IS: (COMAR 10.16.07.05) (Check one)

☐ Bound composition book ☐ Spiral notebook ☐ Individual record ☐ Electronic medical record

9. CPR CERTIFIED STAFF *Two adults with current cardiopulmonary resuscitation (CPR) certification are required on duty at camp at all times.*
Number of adult staff certified in CPR by a national certifying organization: (COMAR 10.16.07.04) _____10. FIRST AID CERTIFIED STAFF *Two adults with current first aid are required on duty at camp at all times.*
Number of adult staff certified in first aid by a national certifying organization: (COMAR 10.16.07.04) _____

F. EMERGENCY PROCEDURES INFORMATION.

Attach a copy of the camp's emergency procedures. (COMAR 10.16.06.34)

G. CHILD ABUSE PREVENTION AND REPORTING

Attach a copy of the camp's child abuse prevention and reporting procedures. (COMAR 10.16.06.35)

H. CRIMINAL BACKGROUND CHECK INFORMATION. (COMAR 10.16.06.21)

1. PERSONNEL ADMINISTRATOR NAME (FIRST AND LAST):

2. PERSONNEL ADMINISTRATOR PHONE NUMBER:

3. DOES THE PERSONNEL ADMINISTRATOR HAVE A CRIMINAL BACKGROUND INVESTIGATION ON FILE WITH DHMH? ☐ Yes ☐ No4. HAS THE PERSONNEL ADMINISTRATOR COMPLETED THE CONSENT FOR RELEASE OF INFORMATION/BACKGROUND CLEARANCE REQUEST FORM FROM MARYLAND CHILD PROTECTIVE SERVICES? ☐ Yes ☐ No

Attach Release Form to completed application, must have original signature and notary.

I. YOUTH CAMP PROGRAM INFORMATION

1. ARE CAMP TRIPS PROVIDED?

☐ NO

☐ YES **Attach the camp's safety plan for camp trips. (COMAR 10.16.06.52)**

Indicate trip dates:

☐ NO

Method of transportation:

☐ NO

3. ARE SPECIALIZED ACTIVITIES PROVIDED?

☐ NO

The safety plan must meet COMAR 10.16.06.52 and other applicable regulations as indicated.

- Adventure Camp (Climbing Wall, Low Ropes if belay or spotting required, Paintball, Inline Skating, Skateboarding, Snowboarding, or similar activity) (Safety plan must also meet COMAR 10.16.06.51)
- Air Guns (Safety plan must also meet COMAR 10.16.06.48)
- Archery (Safety plan must also meet COMAR 10.16.06.49)
- Cycling (Safety plan must also meet COMAR 10.16.06.51)
- Gymnastics (Safety plan must also meet COMAR 10.16.06.51)
- Go Karts (Safety plan must also meet COMAR 10.16.06.51)
- Hang Gliding (Safety plan must also meet COMAR 10.16.06.51)
- High Ropes (Safety plan must also meet COMAR 10.16.06.51)
- Horseback Riding (Safety plan must also meet COMAR 10.16.06.50)
- Motor Vehicles (Safety plan must also meet COMAR 10.16.06.51)
- Natural Bathing Beach (Safety plan must also meet COMAR 10.16.06.47)
- Rappelling (Safety plan must also meet COMAR 10.16.06.51)
- Riflery (Safety plan must also meet COMAR 10.16.06.48)
- Rock Climbing (Safety plan must also meet COMAR 10.16.06.51)
- Snow Skiing (Safety plan must also meet COMAR 10.16.06.51)
- Spelunking (Safety plan must also meet COMAR 10.16.06.51)
- Swimming (Safety plan must also meet COMAR 10.16.06.47) (Obtain operating permit from pool management or local health department)
- Watercraft Activities (Canoeing, Kayaking, Boating, Sailing, Water Skiing, Windsurfing, White Water Rafting)
(Safety plan must also meet COMAR 10.16.06.47)

If you add a new specialized activity, you must obtain prior approval from this Office. Contact DHMH immediately.

[illegible]

4. SUPERVISION PROVIDED DURING ROUTINE ACTIVITIES See COMAR 10.16.06.54. If necessary, attach additional sheet.				33
CAMPER'S AGE	GROUP SIZE	NUMBER OF ADULT (S) (18 AND OLDER) SUPERVISING CAMPER GROUP	NUMBER OF ASSISTANT COUNSELORS (16-17 YEAR OLDS) SUPERVISING CAMPER GROUP	

I. WORKER'S COMPENSATION ACT COMPLIANCE STATEMENT Indicate compliance with workers compensation act.

Maryland Health-General Code Annotated §1-202 requires that before any license, certificate or permit may be issued under the Health-General Article; the employer must file a certificate of compliance listing a workers' compensation insurance policy or binder number. This statement of compliance is based on the workers' compensation law applicable in the state in which the licensee is based.
(Check one and provide requested information.)

☐ I have workers' compensation insurance.
 Insurance Company _____
 Policy or Binder number _____

☐ Attach a copy of the certificate of compliance with the Maryland Workers' Compensation Act.

J. YOUTH CAMP REGULATIONS (COMAR 10.16.06) COMPLIANCE STATEMENT. Read and sign compliance statement.

I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06.s of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any COMAR 10.16.06. adopted by the Department under this subtitle may result in an abatement order or closure order or denial, suspension, or revocation of youth camp certification or letter of compliance. *If you have questions, please call DHMH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.*

X _____

APPLICANT'S SIGNATURE: *Must be a person who owns, supervises, controls, conducts, or manages a youth camp.*

DATE _____

This document can be found on the DHMH website at:
<http://phpa.dhmh.maryland.gov/OEHFP/CHS/Shared%20Documents/ApplicationforNewYouthCamp.pdf>

Maryland Department of Health and Mental Hygiene
 Center for Healthy Homes and Community Services
 Youth Camp Application Fee Chart
 Effective January 1, 2017

Day Camps		
Camper Days	Regular Fee	"Good Standing" Fee
1 to 500	\$190	\$45
501 to 2,000	\$500	\$125
2,001 to 5,000	\$665	\$165
5,001 or more	\$855	\$215

Residential, Day & Residential, Trip, or Travel Camps		
Camper Days	Regular Fee	"Good Standing" Fee
1 to 700	\$500	\$125
701 to 5,000	\$1,000	\$250
5,001 to 16,000	\$1,500	\$375
16,001 or more	\$2,000	\$500

Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camps
How to Achieve “Good Standing” with the Department

1. Submit applications on time.
 - a. 60 days before opening for new camps
 - b. 30 days before opening for renewing camps
2. Submit annual report to the Department within 4 weeks of the end of camp each year.
3. Pay all fees owed to the Department.
4. Have no critical violations on any Departmental inspection within the past 2 years.
 - a. See Page 2
5. While in “Good Standing” with the Department, submit the self-assessment to the Department within 4 weeks of the end of camp each year.

Youth Camp Application Fees for Camps in "Good Standing"

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As defined in COMAR 10.16.06.02B

(17) "Good standing" means:

(a) Compliance with the:

- (i) Annual report and self-assessment submission requirements as specified in Regulation .06 of this chapter; and
- (ii) Application procedure and fee requirements as specified in Regulation .08 of this chapter; and

(b) A camp that in the previous calendar year paid the application fee as set forth in COMAR 10.01.17.02; and

(c) Had no critical violations of this chapter found by the Department during an inspection:

- (i) In the last 2 calendar years; or
- (ii) For a camp in good standing, in the last calendar year that an inspection took place.

(11) "Critical violation" means failure to comply with:

- (a) Regulation .07 of this chapter; (*Certification or Letter of Compliance*)
- (b) Regulation .10 of this chapter; (*Time period for correction of violations*)
- (c) Regulation .21 of this chapter; (*Background checks and clearances*)
- (d) COMAR 10.16.07.03A(1) and (2); (*Health plan approved annually, present at camp*)
- (e) A majority of the required procedures in COMAR 10.16.07.03A(4) and (5); (*Health plan/medication procedures*)
- (f) COMAR 10.16.07.04; (*Health Supervisor and 2 staff with CPR and First Aid*)
- (g) COMAR 10.16.07.08A—C; (*Camper health form – Doctor, health issues, Parent/Emergency contact*)
- (h) A majority of the required procedures in Regulation .34A of this chapter; (*Emergency Plan*)
- (i) A majority of the required procedures in Regulation .35B of this chapter; (*Child Abuse Prevention and Reporting*)
- (j) Regulation .46A(1) and (2) of this chapter; (*Fire – compliance and fire marshal inspection*)
- (k) Regulation .47C and F(6)—(9) of this chapter; (*Swimming and watercraft supervision*)
- (l) Regulation .48D(1) of this chapter; (*Riflery and airgun supervision*)
- (m) Regulation .49C of this chapter; (*Archery supervision*)
- (n) Regulation .50B of this chapter; (*Horseback riding supervision*)
- (o) Regulation .51B of this chapter; (*Other specialized activity supervision*)
- (p) Regulation .52A(1) and B(1) of this chapter; (*Safety plans for all specialized activities/trips, director is present*)
- (q) A majority of the required procedures in Regulation .52A(2)—(5) of this chapter; (*Risks, responsibilities, rules, communication for specialized activities and trips*)
- (r) Regulation .53A(1) and (2) of this chapter; or (*Transportation – State law, safety plan*)
- (s) Regulation .54 of this chapter. (*Routine supervision*)

Directions: Find the chart which corresponds to your camp type. Then, using the camper days, determine the application fee.

Camper days are calculated by multiplying the average number of campers per day times the number of days the camp will operate.

"Good Standing" Day Camp Fee Chart	
Camper Days	Application Fee
1 to 500	\$45.00
501 to 2,000	\$125.00
2,001 to 5,000	\$165.00
5,001 or more	\$215.00

"Good Standing" Residential, Day & Residential, Trip, or Travel Camp Fee Chart	
Camper Days	Application Fee
1 to 700	\$125.00
701 to 5,000	\$250.00
5,001 to 16,000	\$375.00
16,001 or more	\$500.00

**CRIMINAL
BACKGROUND
CHECKS
AND
BACKGROUND
CLEARANCES**

CRIMINAL HISTORY RECORD CHECK FOR PERSONNEL AT YOUTH CAMPS

Maryland Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore, MD 21202-1608
(410) 767-8417 Fax (410) 333-8926
Toll Free 1-877-4MD-DHMH extension 78417

A camp operator must comply with the Family Law Article, §§ 5-560-568, Annotated Code of Maryland, regarding criminal history record checks for employees and employers of facilities that care for or supervise children. The employer must keep on file for each employee the results of the criminal history record check. The employer must be able to show the Department of Health and Mental Hygiene representative the criminal history record check. Fingerprint-supported criminal history record checks are done through the Maryland Public Safety and Correctional Services, Criminal Justice Information System (CJIS).

Background checks through other sources are not accepted.

CJIS STOREFRONT FINGERPRINTING CENTER is located at the Reisterstown Road Plaza Office Complex, 6776 Reisterstown Road, Suite 102, Baltimore, Maryland. Hours of operation are Monday, Tuesday, Wednesday and Friday 8:30 a.m. to 5:00 p.m., Thursday 8:30 a.m. to 6:30 p.m. and the 1st and 3rd Saturdays each month 8:30 a.m. to 4:30 p.m. Phone: 410-764-4501 or 1-888-795-0011, Monday through Friday, 8:00 a.m. to 5:00 p.m. Web site: <http://dpscs.maryland.gov/publicservs/>

AUTHORIZATION NUMBER - If the employer does not have a CJIS authorization number, complete the "General Registration Form" and submit to CJIS via fax or mail. *Provide an email address that will be used to receive the criminal history results.* The CJIS Central Repository will mail your authorization number. Notify CJIS immediately of any changes in your contact information using the authorization update form. Both forms can be found on the CJIS website at: <http://dpscs.maryland.gov/publicservs/bgchecks.shtml>.

CRIMINAL HISTORY RECORD CHECK APPLICATIONS – Once you have an authorization number and **before the employee works at the camp** submit an application for criminal history record check to CJIS Central Repository using the Livescan Pre-Registration Application.

LIVESCAN PRE-REGISTRATION APPLICATION – The application may be submitted electronically using scanned fingerprints by using the CJIS Storefront Fingerprinting Center, a CJIS MVA fingerprinting site, or an approved private provider. There is a link to the LIVESCAN PRE-REGISTRATION APPLICATION form online at <http://dpscs.maryland.gov/publicservs/fingerprint.shtml>. The ORI #: MD004455Y is required and the reason fingerprinted is **CHILD CARE**

CRIMINAL HISTORY RECORD CHECK FOR EMPLOYEES OUTSIDE MARYLAND –

1. Write to CJIS-Central Repository P.O. Box 32708, Pikesville, Maryland 21282-2708, or call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request a fingerprint card.
2. Mail the fingerprint card and associated fee to CJIS-Central Repository P.O. Box 32708 Pikesville Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
3. Include a check or money order made out to "CJIS Central Repository". See the schedule of Associated Fees at <http://dpscs.maryland.gov/publicservs/bgchecks.shtml#fees>.
4. You may expect a response in 10 - 15 business days.

Add "ORI #: MD004455Y" and "CHILD CARE" to the upper right hand corner of the card.

EMPLOYEES –When completing the LIVESCAN PRE-REGISTRATION APPLICATION, employees must use the camp employer's authorization number.

PERSONNEL ADMINISTRATOR – Each camp must have a personnel administrator with a background check on file with DHMH-CHHCS. The personnel administrator may be the owner, director, or a human resources staff member who reviews the background check results and determines if an individual may work at camp. The personnel administrator must complete his/her background check using the DHMH authorization number (9400019171) and the ORI number (MD004455Y).

FINGERPRINTS – Electronic fingerprinting is available at the CJIS Storefront Fingerprinting Center. The cost is \$20.00 per person. Please arrive at least one half hour before closing. Fingerprinting services are available from private providers authorized by CJIS. A list of providers is online at <http://dpscs.maryland.gov/publicservs/fingerprint.shtml>. Check with the private provider for their fingerprinting fees which are separate from the processing fee.

FEES - The processing fee for an application is \$30.00. This does not include the fingerprint fee. The fee is reduced to \$28.75 for "volunteers" please see details below. The CJIS Storefront Fingerprinting Center does not accept cash. Please use a corporate check, certified check or money order made payable to CJIS- CENTRAL REPOSITORY. CJIS will accept personal checks, Visa or MasterCard debit or credit cards only if the check writer or cardholder is present.

RESULTS –Call CJIS Customer Service at (410) 764-4501 or 888-795-0011 for help if you do not receive the Maryland or FBI criminal history record information in 48 hours. You receive your record checks by email. Keep the original results in a secure manner on file at the camp office.

REJECTED FINGERPRINTS – If the employee's fingerprints are rejected because of poor quality, the employer and employee will be notified. Reprints must be received within 60 days of the date on the reject letter or the employee must reapply and pay application and fingerprinting fees.

365 DAY REQUEST – When the employee has completed a criminal history record check for another child care employer within the past year, the 365 Day Request form may be used instead of the full application with fingerprints. There is no cost for processing a 365 Day Request. Fingerprints are not required. CJIS **must** process the form within 365 calendar days of CJIS's receipt of the employee's original application.

RETURNING EMPLOYEE – A repeat criminal history record check is not required if the original result with the camp listed as the employer is on file at camp and there is a contractual agreement for the employee to return to duty and there has not been a termination of employment.

EMPLOYEES UNDER AGE 18 - The criminal history record check is required for employees under age 18. CJIS accepts applications for any person 14 years old or older.

VOLUNTEERS - An employer at a youth camp may ask volunteers to apply for a criminal history record check, but **this is not required**. Please call CJIS at (410) 764-4501 for additional information. The FBI fee is reduced as long as the word "CHILD CARE/VOLUNTEER" is written on the application in the Reason Fingerprinted box. The CJIS-015 purple form must be checked "STATE AND FBI VOLUNTEER". The total fee is \$28.75.

Department of Public Safety & Correctional Services

Fingerprinting Services / Fingerprinting Courses

<http://dpscs.maryland.gov/publicservs/fingerprint.shtml>

Commercial Fingerprinting Services (Private Providers)

Private providers are authorized by COMAR Regulation 12.15.05 to submit fingerprints directly to the Maryland Criminal Justice Information System for the purpose of obtaining criminal history record checks. Criminal history record information obtained under this program is mailed directly to you or the agency(s) of your choice. No information regarding your criminal history is given to the private provider. In addition to the fees required by the State of Maryland for criminal history record checks the private provider will collect an additional service fee as determined by the provider. The following list of private providers is published for your convenience and should not be considered an endorsement of any particular provider by the State of Maryland:

PRIVATE PROVIDERS	ADDRESS	PHONE
<u>1A Fingerprinting</u>	4367 Hollins Ferry Road Ste 3A Halethorpe, MD 21227	443.297.0351
<u>3M Cogent Fingerprinting Services</u> c/o Bay Shore Services, Inc.	1235 Pemberton Dr. Salisbury, MD 21801	410.341.0307 x106
<u>3M Cogent Fingerprinting Services</u> Main-One (M-1) Solutions, Inc	4300 Forbes Blvd. Suite 220 Lanham, MD 20706	301.702.7200
3M Cogent Fingerprinting Services c/o Fairmount Heights Police Department	6100 Jost Street Fairmount Heights, MD 20743	301.883.9472
<u>3M Cogent Fingerprinting Services</u> c/o Xecutive Security Investigations Group	821 E. Baltimore St. Baltimore, MD 21202	410.605.0947
<u>911 Security & Investigations, LLC</u>	8115 Fenton Street Suite 303 Silver Spring, MD 20910	301.755.6138

PRIVATE PROVIDERS	ADDRESS	PHONE
<u>Absolute Investigative Services</u>	604 E. Joppa Road Towson, MD 21286	410.828.6460
<u>Absolute Investigative Services</u>	10514 D Racetrack Road Berlin, MD 21811	410.973.2482
<u>Absolute Investigative Services, Inc.</u>	139 N. Main Street #103 Bel Air, Maryland 21014	410.420.6923
<u>Allied Barton Security Services</u>	36 South Charles Street Suite 2204 Baltimore, MD 21201	443.725.9398
<u>All American Protective Services, LLC</u>	6701 Democracy Blvd. Suite 110 Bethesda, MD 20817	301.571.9479
<u>All American Protective Services, LLC</u>	12501 Prosperity Drive Suite 200 Silver Spring, MD 20904	240.670.7952
<u>All American Protective Services, LLC</u>	7361 Calhoun Place Suite 485 Rockville, MD 20855	301.296.4499
<u>American Fingerprinting Services</u>	3 Bethesda Metro Center Suite 700 Bethesda, MD 20814	301.961.1998
<u>Apex Investigative Services</u>	1916 Crain Hwy S. Ste. 11 Glen Burnie, MD 21061	410.590.3700
<u>Apex Nursing Services</u>	6480 New Hampshire Ave. Suite 305 Takoma Park, MD 20912	301.448.1051
<u>B&B Insurance Group</u>	1305 S Division St. Ste. 14 Salisbury, MD 21801	443.736.8425
<u>Biometrics Identity Verification System</u>	1005 North Point Blvd Suite 728	443-503-6073

PRIVATE PROVIDERS	ADDRESS	PHONE
	Baltimore, MD 21224	
<u>Biometrics Identity Verification System</u>	5010 Sunnyside Avenue #300 Beltsville, Maryland 20705	301.477.3210
<u>Biometrics Identity Verification System</u>	10410 Kensington Parkway Suite 100B Kensington, MD 20895	240.833.3268 () 301.822.4552 (fax)
<u>Biometrics Identity Verification System</u>	4005 Seven Mile Lane Pikesville, MD 21208	443.213.8908 () 443.213.8605 (fax)
<u>Broadway Services, Inc.</u>	3709 E. Monument St. Baltimore, Maryland 21205	410.563.6949
<u>Cambridge Federal</u>	104 Tech Park Drive Cambridge, MD 21613	410.221.7546
<u>Cambridge Federal</u>	112 Saint Claire Place Suite 201 B Stevensville, MD 21666	410.221.7546
<u>Dynamic, Inc.</u>	5209 York Road, Room B2A Baltimore, MD 21212	443.518.6017
<u>E House Executive Security Professionals, Inc</u>	4710 Auth PI Suite 420 Suitland, MD 20746	301.899.2828
<u>Essential Support Services</u>	2028 Liberty Road Suite 102 Eldersburg, MD 21784	443-547-2223 1-866-388-9606
<u>Fingerprint ASAP</u>	6214 Reisterstown Road Baltimore, MD 21215	443.213.8245
<u>Fingerprint Express</u>	2401 Blueridge Avenue Suite 401	301.728.4947

PRIVATE PROVIDERS	ADDRESS	PHONE
	Silver Spring, MD 20902	
<u>FYI Fingerprints</u>	3696 Park Avenue Ellicott City, MD 21043	410.418.4657
<u>Grand Mission Consult</u>	7515 Annapolis Rd #203 Hyattsville, MD 20784	301.429.0525
Grand Mission Consult c/o LIVE SCAN PRO	4920 Niagara Road, Suite 102 College Park, MD 20740	301.637.7078 301.345.9100
Grand Mission Consult c/o L.A.W Livescan Consultant	1826 Woodlawn Drive, Suite #2 Woodlawn, Maryland 21207	443.200.2167 443.562.8968
<u>Heritage Training & Shooting Center</u>	4537 Metropolitan Court Frederick, MD 21704	240.341.4006
<u>Hughes Barney Investigations</u>	9315 Largo Drive West Suite 210 Largo (Upper Marlboro), MD 20774	301.333.1728
<u>Inquiries, Inc.</u>	8707 Commerce Dr. Suite A Easton, MD 21601	866.987.3767
<u>IOTA Security and Detective Agency, Ltd</u>	11410 Marriottsville, Rd. Bldg. #7 Marriottsville, MD 21104	410.750.3278
Law Enforcement Institute of MD	30385 Three Notch RD Charlotte Hall, MD 20622	240.309.4019
<u>Maryland Livescan, Inc.</u>	The Empire Towers Building 7310 Ritchie Hwy. Suite 610 Glen Burnie, MD 21061-3290	410.761.6700

PRIVATE PROVIDERS	ADDRESS	PHONE
<u>Mid-Atlantic Regional Investigations, LLC</u>	1202 West Street Annapolis, MD 21401	888.320.7775
Morning Star Identity Solutions	101 Lakeforest Boulevard Suite 402 Gaithersburg, MD 20877	301.977.7393 (local) 1.844.977.7393 (toll-free)
<u>MorphoTrust USA (L-1)</u> c/o BITHGROUP Technologies	113 Monument Street Baltimore, MD 21201	877.467.9215
<u>MorphoTrust USA (L-1)</u> c/o Securitas Security Services	1101 Opal Court Suite 211 Hagerstown, MD 21740	877.467.9215
<u>Mustardseed Health Care Services LLC</u>	15 National Pl Westminster, Md 21557	240.439.4373 (local) 1.844.239.6721 (toll-free)
<u>Mustardseed Health Care Services LLC</u>	198 Thomas Johnson Dr. Suite 205 Frederick, MD 21702	240.439.4373 (local) 1.844.239.6721 (toll-free)
<u>Optimal Health Care, Inc.</u>	8182 Lark Brown Rd Suite 202 Elkridge, MD 21075	301.790.4962
<u>Optimal Health Care, Inc.</u>	6 West Washington Street Hagerstown, MD 21740	301.790.4962
<u>Optimal Health Care, Inc.</u>	174 Thomas Johnson Dr. Ste 201L Frederick, MD 21702	301.790.4962
<u>Optimal Health Care, Inc.</u>	McMullen Building	301.790.4962

PRIVATE PROVIDERS	ADDRESS	PHONE
	138 Baltimore St. Suite 202 Cumberland, Maryland, 21502	
<u>Optimal Health Care, Inc.</u>	1550 Deep Creek Dr. Unit G McHenry, Maryland, 21541	301.790.4962
<u>Police Guard Services</u>	7935 Central Avenue Capitol Heights, MD 20743	301.456.8766
<u>Positive I.D., Inc.</u>	103 Sudbrook Lane #2 Pikesville, MD 21208	410.602.2479
<u>Prevent First</u>	3710 Riviera Street #1A Temple Hills, MD 20748	301.423.5414
Procure Home Health Providers	549 N. Centre Street, #1 Cumberland, MD 21502	240.362.7653
<u>ProtectPro, LLC</u>	1714 W. Jarrettsville Road Jarrettsville, MD 21084	410.440.4122
Qualls Security & Investigations	205 E. Main St Elkton, MD 21921	410.398.4444
<u>Quick Fingerprints</u>	11605 Crossroads Circle Suite F Middle River, MD 21220	855.463.7226
<u>Renox Group, LLC</u>	ID Solutions 9500 Annapolis RD Suite B2 Lanham, MD 20706	301.850.1148
<u>Safe Hire Solutions</u>	180 Main Street Prince Frederick, MD 20678	240.375.7601

PRIVATE PROVIDERS	ADDRESS	PHONE
<u>Scotty's Investigations, Inc.</u>	515 Regina Avenue Cumberland, MD 21502	301.777.0232
Secure Fingerprints	9801 Fallard Court Upper Marlboro, MD 20772	410.350.1540
<u>Securpros</u>	9300 Annapolis Road #103 Lanham, MD 20706	301.459.8322
<u>The Fingerprint Doctor</u>	312 N.Charles Street Suite # 300	410.244.1756
<u>The Fingerprint Doctor</u>	6556 Reisterstown Rd Plaza Baltimore, MD 21215	410.585.0870
<u>The Training Point</u>	601 Seventh Street Suite 302 Laurel, MD, 20707	301.776.2976
<u>Thomas Security</u>	1325 Mt. Hermon Road Salisbury, MD 21804	410.548.5029
<u>Three Brothers</u>	3061 Frederick Avenue Baltimore, MD 21223	410.566.9112
<u>Trident Security Group, LLC.</u>	9026 Liberty Road Randallstown, MD 21133	443-800-1949
<u>United Security & Communications, Inc.</u>	5415 Southern Maryland Blvd. Wayson's Corner (Lothian), MD 20711	301.952.8724
<u>Worth-A-Shot, Inc.</u>	8424 Veterans Highway Suite #11 Millersville, MD 21108	443.688.6521

CJIS Operated Fingerprinting Services

Location: 6776 Reisterstown Road
(West side of Reisterstown Road Plaza
Mall)
Suite 102 (first floor)
Baltimore, MD 21215
For directions, go to
<http://www.mapquest.com>

Phone: 410-764-4501
1-888-795-0011 (toll free)

Hours of Operation Monday-Friday 8:30a-5pm

**Please contact any one of the Private
Providers listed above for the late
evening and weekend operation hours
they provide.**

Closed on designated State holidays

The following locations are available by appointment only:

Motor Vehicle Administration - Bel Air
501 West MacPhail Road
Bel Air, MD 21014

Motor Vehicle Administration - Frederick
1601 Bowman's Farm Rd.
Frederick, MD 21701

Motor Vehicle Administration - Waldorf
St. Charles Business Park
11 Industrial Park Drive
Waldorf, MD 20602

Motor Vehicle Administration - Salisbury
251 Tilghman Rd
Salisbury, MD 21801

Motor Vehicle Administration - Glen Burnie
6601 Ritchie Hwy, N.E.
Glen Burnie, MD 21062

Call for an appointment: 410-764-4501 or 1-888-795-0011 (toll free)

Government Operated Services

AGENCY	ADDRESS	PHONE
<u>Annapolis Police Department</u>	199 Taylor Avenue Annapolis, MD 21401	410.268.9000
<u>Berlin Police Department</u>	10 William Street Berlin, MD 21811	410.641.1333
<u>Cecil College Public Safety Department</u>	1 Seahawk Dr. North East MD 21901	410.287.1619
<u>Charles County Sheriff's Office</u>	11110 Mall Circle Waldorf, MD 20603	301.609.6438
<u>Cecil county sheriff's Office</u>	107 Chesapeake Blvd. Elkton, MD 21921	410.392.2118
<u>Frederick County Sheriff's Office</u>	110 Airport Drive East Frederick, MD 21701	301.600.4058
<u>Frostburg State University Police</u>	101 Braddock Road Frostburg, MD 21532	301.687.4223
<u>Garrett County Sheriff's Office</u>	311 E Alder St Oakland MD 21550	301-334-5040
<u>Glenarden Police Department</u>	8600 Glenarden Parkway Glenarden, MD 20706	301.772.3214
<u>Harford County Sheriff's Office Headquarters</u>	45 South Main Street Bel Air, MD 21014	410.836.5470
<u>Harford County Sheriff's Office Northern Precinct</u>	3726 Norrisville Road Jarrettsville, MD 21084	410.692.7880
<u>Harford County Sheriff's Office Southern Precinct</u>	1305 Pulaski Highway Joppa, MD 21085	410.612.1717
<u>Laurel Police Department</u>	811 Fifth St. Laurel, MD 20707	301.498.0092
<u>Salisbury University Police</u>	110 Power Street	410.548.2900

AGENCY	ADDRESS	PHONE
<u>Fingerprint Services - EC149</u>	Salisbury, MD 21801	
<u>Rockville City Police Department</u>	2 W. Montgomery Avenue Rockville, MD 20850	240.314.8924
<u>UMBC Police Department</u>	1000 Hilltop Circle Baltimore, MD 21250	410.455.1685
<u>University of Maryland, College Park</u>	Department of Public Safety Pocomoke Building 7569 Baltimore Avenue College Park, MD 20742	301.405.5758

FOR FAST AND ACCURATE SERVICE

1. If you are requesting a background check for employment or licensing purposes you must have an agency name and authorization number
2. If your background check is being sent to a government agency you may also need an ORI number.
3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification)
4. Fill out the attached form, print it and bring it to any fingerprinting center.
Livescan Pre-registration Application
5. Bring payment as indicated below. Major credit cards and checks are accepted. Cash is not accepted at the State Operated Fingerprinting Centers.

Effective December 12, 2016, money orders will no longer be accepted as payment for fingerprint services at the CJIS Storefront location. Money Orders will continue to be accepted till Feb 1, 2017 at the Hazmat locations.

Associated CJIS - CR Fees

Fees are required to process each criminal background record check request.

All fees must be paid by credit card or check in United States currency. The Central Repository cannot accept cash.

Full background [state and FBI] for authorized agencies only	\$30.00
child care volunteers	\$28.75
Maryland Mentor	\$15.00 with certification card
State background check only	\$18.00
with Gold Seal	\$19.00
Criminal Justice	
full background	No fee
state only	No fee
Attorney/Client civil	\$18.00
Attorney/Client pending criminal case	No fee

There is a \$20.00 fingerprint service fee per customer. There is a maximum of five ink cards printed per customer. You may choose to have your fingerprints taken at another agency. Make sure to check with that agency for their fingerprinting fees as fees may vary.



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS-CENTRAL REPOSITORY
REGISTRATION FOR AUTHORIZATION FOR RECORD CHECKS

- ☐ This is a NEW registration.
☐ This is a CHANGE to a current registration.

List Authorization Number if known:

I. COMPANY OR AGENCY NAME:

CONTACT PERSON:
(Person who will be handling the criminal history record information from CJIS)

CONTACT PERSON'S TITLE:

CONTACT PERSON'S TELEPHONE NUMBER:

MAILING ADDRESS:

CITY, STATE AND ZIP CODE:

E-mail address

Fax Number:

Business License#:

Please include a copy of your business license, IRS paperwork EIN# and a short bio about your agency.
.....

II. REASON FOR REQUEST:

___ ADULT DEPENDENT CARE (For Maryland Adult Dependent Program Only)

___ ATTORNEY/CLIENT

☒ CHILD CARE (Licensed Agencies working with Children in Maryland Only)

___ CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)

___ GOVERNMENT EMPLOYMENT - Federal ___ State ___ Local ___

___ GOVERNMENT LICENSING/CERTIFICATION

IF AUTHORIZED BY STATUE, ENTER STATUTORY CITATION:

III. CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

SIGNATURE

Date:

TITLE

MAIL, Email or FAX COMPLETED FORM TO: CJIS AUTHORIZATION ADMINISTRATOR
POST OFFICE BOX 32708
PIKESVILLE, MARYLAND 21282-2708
Dlcjiscustomerservice7_dpccs@maryland.gov
Fax# 410-653-6320 or 5690



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CENTRAL REPOSITORY
P.O. BOX 32708
PIKESVILLE, MD. 21282-2708

AUTHORIZATION UPDATE FORM

AGENCY AUTHORIZATION NUMBER: _____

- ☐ Adult Dependent Care Agency
 ☐ Attorney/Client
 ☐ Child Care Agency
 ☐ Criminal Justice Agency
☐ Government Employment Agency
 ☐ Government Licensing Agency
 ☐ Public Housing Authority

Please advise us immediately of any change to your CJIS-CR authorization information. Please type or print all information clearly.

1) Current Agency Name: _____

2) New Agency Name: _____

3) Current Contact Person: _____

4) New Contact Person: _____

5) Old Mailing Address: _____

(Street)

(City)

(State)

(Zip Code)

New Mailing Address: _____

(Street)

(City)

(State)

(Zip Code)

6) Phone Number: _____ Fax Number: _____

7) E-Mail Address: _____

Signature

Title

Date

You may mail or FAX the form to:

CJIS-Central Repository
P.O. Box 32708
Pikesville, MD 21282-2708
FAX: (410) 653-6320
Alternate FAX: (410) 653-5690

Form ITCD-126



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

Name:			
Date of birth:		SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (Please check)
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Please check)			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:		Evening Phone:	Driver's License #:

AGENCY INFORMATION

Agency Authorization #:	
ORI # (if required): MD004455Y	Reason fingerprinted? CHILD CARE
Position Applied for:	
Request Type: (Choose one ONLY) <input type="checkbox"/> Adult Dependent Care <input type="checkbox"/> Attorney/Client <input checked="" type="checkbox"/> Child care <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Gold Seal/ Adoption <input type="checkbox"/> Gold Seal/Letter/VISA <input type="checkbox"/> Government Employment	<input type="checkbox"/> Government Licensing or Certification <input type="checkbox"/> Immigration/VISA <input type="checkbox"/> Individual Challenge <input type="checkbox"/> Individual Review <input type="checkbox"/> MSP Licensing <input type="checkbox"/> Private Party Petition <input type="checkbox"/> Public Housing

Mail Response to:

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:
Address:
City, State, Zip code:

DHMH Authorization #



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

Name:

Date of birth:

SSN:

Gender: ☐ Male ☐ Female (Please check)

Height: ft. inches

Weight: lbs.

Eye Color:

Hair Color:

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other (Please check)

Place of Birth:

Citizenship:

Current address:

City:

State:

ZIP Code: -

Daytime Phone:

Evening Phone:

Driver's License #:

AGENCY INFORMATION

Agency Authorization #: 9400019171

ORI # (if required): MD004455Y

Reason fingerprinted? CHILD CARE

Position Applied for:

Request Type: (Choose one ONLY)

☐ Adult Dependent Care☐ Attorney/Client☒ Child care☐ Criminal Justice☐ Gold Seal/ Adoption☐ Gold Seal/Letter/VISA☐ Government Employment☐ Government Licensing or Certification☐ Immigration/VISA☐ Individual Challenge☐ Individual Review☐ MSP Licensing☐ Private Party Petition☐ Public Housing

Mail Response to:

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:

Address:

City, State, Zip code:



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CENTRAL REPOSITORY
P.O. BOX 32708
PIKESVILLE, MD. 21282-2708

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365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK

NAME _____
(Last) (First) (MI)

ADDRESS _____
(Number) (Street) (P.O. Box)

(City) (State) (Zip Code)

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____/____/____

(This information is required under Article 27, § 742-755, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

_____ (12 DIGIT NUMBER)

I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.

SIGNATURE OF EMPLOYEE _____ DATE _____

TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.

(EMPLOYER NAME)

(ADDRESS)

(CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: _____

AUTHORIZED SIGNATURE: _____

DATE: _____

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32708, PIKESVILLE, MD. 21282-2708
Customer Assistant Desk: (410) 764-4501 Fax#: 410-653-5690 Alt. Fax#: 410-653-6320

FOR CJIS CENTRAL REPOSITORY USE ONLY

This request can not be processed because:

- _____ this is not a valid reference number
- _____ this is not a valid authorization number
- _____ this reference number has not been received at the Central Repository
- _____ this authorization number is not approved for this request.
- _____ the application associated with this reference number was received more than 365 days before receipt of this request.
- _____ requested information is not completed

Child Protective Services (CPS) Background Clearance Form for Youth Camp Personnel Administrator
(See separate instructions for camp employees.)

The form is on the DHMH Youth Camp web page:

<http://phpa.dhmdh.maryland.gov/OEHFP/CHS/Pages/youth-camp-forms.aspx>

Most Requested Forms and Documents

- CPS Release Form - Personnel Administrator

USE NEW FORM: CPS/Adam Walsh Background Request Form, dated 02/2016. Do not use the old form, it will not be processed.

Part I; PURPOSE OF SEARCH is complete, do not add or change Part I.

Start with Part II: SEARCH INFORMATION, fill in all applicable information on a computer, then print and sign before a notary.

Handwritten forms will be returned to the sender, they will not be processed.

MAILING INSTRUCTIONS: For 2016, instead of mailing the forms to the local Social Services, the Maryland Department of Human Resources (DHR) will process the background clearances for Youth Camp employees or personnel administrators. **KEEP A COPY OF COMPLETED FORMS.**

Mail the original to:
Maryland Department of Human Resources
Social Services Administration
In-Home Services
311 W. Saratoga Street, Room 553
Baltimore, MD 21201

Other helpful hints:

- If the Social Security number begins with a zero (0), it might not enter appear on the printed copy of the form, if it does not, add the 0 to the printed copy.
- Provide Social Security number (if issued), family member information, race, etc., on the form, **all of this information is needed to complete an accurate search.**
- There is no fee from DHR for this service.
- For an applicant under 16, the form must also be signed by a parent or guardian and notarized.
- Sign in blue ink.



CONSENT FOR RELEASE OF INFORMATION

CPS BACKGROUND/ADAM WALSH BACKGROUND CLEARANCE REQUEST

*****PLEASE COMPLETE THIS FORM ON LINE AND THEN PRINT*****

Part I: PURPOSE OF SEARCH

A. RELEASE TO SELF:

- ☐ 1. To determine if I have been found responsible for an "indicated" or "unsubstantiated" disposition for a child abuse or neglect investigation.
- ☐ 2. To determine if I have any remaining appeal rights.

SAMPLE

B. RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO:

- | | | | |
|-------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Adoption | <input type="checkbox"/> School Personnel | <input type="checkbox"/> Day Care Center | <input checked="" type="checkbox"/> Youth Camp Personnel Administrator |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Institutional Employee | <input type="checkbox"/> Family Day Care | <input type="checkbox"/> Youth Camp Worker/Volunteer |
| <input type="checkbox"/> Kinship Care | <input type="checkbox"/> CASA | <input type="checkbox"/> Community Mgmt. Entity | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> International Adoption | <input type="checkbox"/> Custody Evaluation | <input type="checkbox"/> Group Home/Residential Treatment Facility | |

Agency/Individual Name

Name of Agency Representative

DHMH - Center for Healthy Homes and Community Services Joseph T. McKenzie, III

Agency Address

Representative's Phone Number

6 St Paul Street, Suite 1301, Baltimore, MD 21202-1608

410 - 767 - 8423 x

Representative's Email

Tommy.McKenzie@Maryland.gov

Part II: SEARCH INFORMATION (To be completed in full by individual whose name is being searched)

APPLICANT'S LAST NAME	FIRST NAME	MIDDLE NAME (Full)	MAIDEN/BIRTH NAME
Doe	Jane	Susan	Dough
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	RACE
123 -45 - 6789	Feb 29, 1992	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	White
OTHER NAMES USED			
N/A			

SAMPLE

NUMBER	STREET NAME	UNIT TYPE//	CITY	STATE	ZIP CODE
321	Main St	Apt A	Baltimore	MD	21202
DAYTIME TELEPHONE NUMBER			EMAIL ADDRESS		
443-555-1234			jdoe@gmail.com		

CURRENT SPOUSE

LAST NAME	FIRST NAME	MIDDLE NAME (Full)	DATE OF BIRTH
Doe	John	Michael	March 1, 1991

FULL NAMES OF ALL CHILDREN (To include adult children and children not residing with you)

LAST NAME	FIRST NAME	MIDDLE NAME (Full)	DATE OF BIRTH
Doe	Susan	Bee	Jan 1, 2015

If more than 3 children, attach additional paper if necessary.

SAMPLE

Have you lived in Maryland in the past? ☒ Yes ☐ No Have you worked or volunteered in Maryland in the past? ☒ Yes ☐ No

If yes to either question, from what years: 2000-2016

PRIOR ADDRESSES (List all within the past 7 years in Maryland.)					
NUMBER	STREET NAME	CITY	STATE	ZIP CODE	DATE
456	Peachtree Lane	Arnold	MD	21012	09/99 - 05/2000

SAMPLE

Part III: AUTHORIZATION

Pursuant to Code of Maryland Regulations § 07.02.07, pertaining to the confidentiality of Child Protective Services investigations and reports, I hereby authorize the Maryland Department of Human Resources (DHR) to notify DHRH - Center for Health Homes and Community Services (agency or individual as listed in Part I) as to whether a local department of social services has identified me as responsible for "indicated" child abuse or neglect in any record maintained by the Maryland Department of Human Resources, any local department of social services, and Child Protective Services.

*******STOP*******REVIEW THAT ALL SECTIONS ARE COMPLETE*****

*****PRINT THIS FORM BEFORE PROCEEDING TO PART IV*****

PART IV: SIGNATURE (If Applicant is under age 16, must be signed by Applicant's parent/guardian)**DATE**

(Print name of signature above)	

PART V: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL BEFORE A NOTARY PUBLIC

City/County of: _____ State of: _____

Acknowledged before me this _____ day of _____, 20 ____.

NOTARY PUBLIC

My commission expires: _____.

PART VI: BACKGROUND CLEARANCE FINDINGS (for Local Department or DHR use only)

	Applicant's Name:	MD CHESSIE ID#:
<input type="checkbox"/>	1. Active Investigation	
<input type="checkbox"/>	2. Sent to DHR or Local Department of Social Services:	Name:
		Date:
<input type="checkbox"/>	3. We have determined that _____ is listed in the state's database as being responsible for an <input type="checkbox"/> Indicated / <input type="checkbox"/> Unsubstantiated disposition of <input type="checkbox"/> Abuse / <input type="checkbox"/> Neglect in reference to an investigation conducted in _____ by _____. Child Protective Service Investigation #: _____. (Unsubstantiated findings may only be released to the MSDE Office of Child Care.)	
<input type="checkbox"/>	4. Holding for appeal	
<input type="checkbox"/>	5. Notification sent to Applicant on	
<input type="checkbox"/>	6. As of this date, _____ the individual whose name was being searched is NOT identified in the state's system.	

State of Maryland-Child Protective Services Program
CONSENT FOR RELEASE OF INFORMATION
CPS BACKGROUND CLEARANCE REQUEST
ADAM WALSH BACKGROUND CLEARANCE REQUEST
INSTRUCTIONS

1. All forms should be completed electronically. Complete the form on-line and then print it. (You may want to save the form to your computer.) **INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED AND WILL CAUSE A DELAY IN THE REQUEST BEING PROCESSED.**
2. Submit a separate form for each individual whose name is to be searched.
3. Provide proof of identity to the Notary Public when you sign Part IV. The Notary's original seal is required on all forms.

For all requests being made by a State's department of social services, the caseworker must verify the applicant's identity. Therefore the form is not required to be notarized.

MAILING INSTRUCTIONS FOR YOUTH CAMPS:

For 2016, instead of mailing the forms to the local Social Services, the Maryland Department of Human Resources (DHR) will process the background clearances for Youth Camp employees or personnel administrators.

Mail the original to:
Maryland Department of Human Resources
Social Services Administration
In-Home Services
311 W. Saratoga Street, Room 553
Baltimore, MD 21201

KEEP A COPY OF COMPLETED FORMS.

NOTE:

- If you have been Issued a Social Security Number, you **MUST** provide it so a thorough search can be conducted.
- Information on family members is requested in the event the applicant has the same name as another person known to the department, to help determine the correct person.
- There is no fee for this service.
- Your signature is only valid for 1 year.
- If the applicant is under 16 years of age, this form is required to be signed by a parent/guardian and notarized.
- The applicant's signature should be signed in blue ink.
- All prior versions of this form are obsolete.

Child Protective Services (CPS) Background Clearance Form for Youth Camp Employees
(See separate instructions for personnel administrator.)

The form is on the DHMH Youth Camp web page:

<http://phpa.dhmmh.maryland.gov/OEHFP/CHS/Pages/youth-camp-forms.aspx>

Most Requested Forms and Documents

- CPS Release Form - Camp Employee

1. **USE NEW FORM:** CPS/Adam Walsh Background Request Form, dated 02/2016. Do not use the old form, it will not be processed. Also, complete the form on a computer, then print and sign before a notary. **Handwritten forms will be returned to the sender.**

2. For camp employees, in Part I: PURPOSE OF SEARCH, under B RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO: mark the box for Youth Camp Worker/Volunteer and under AGENCY/INDIVIDUAL NAME add: Your camp's name or employer, contact person, address, phone and email. Save the form with this information and then have each employee add their personal information before printing the form, see above.

3. **MAILING INSTRUCTIONS:** For 2016, instead of mailing the forms to the local Social Services, the Maryland Department of Human Resources (DHR) will process the background clearances for Youth Camp employees or personnel administrators. **KEEP A COPY OF COMPLETED FORMS.**

Mail the original to:
Maryland Department of Human Resources
Social Services Administration
In-Home Services
311 W. Saratoga Street, Room 553
Baltimore, MD 21201

4. Returning employees: The Certification for Youth Camps regulations do not require an annual background clearance. If you received a response from Social Services indicating the status of the background clearance in 2015 (or before) for a returning employee, you do not have to submit a 2016 form for that employee.

5. Other helpful hints:

- If the Social Security number begins with a zero (0), it might not enter appear on the printed copy of the form, if it does not, add the 0 to the printed copy.
- Provide Social Security number (if issued), family member information, race, etc., on the form, **all of this information is needed to complete an accurate search.**
- There is no fee from DHR for this service.
- For an applicant under 16, the form must also be signed by a parent or guardian and notarized.
- Sign in blue ink.

**Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camps**

**Child Protective Services Background Clearance Form
Frequently Asked Questions**

- 1. What is the difference between the Child Protective Services Background Clearance and the Maryland and FBI criminal background checks?**
 - a. The Child Protective Services Background Clearance provides information from the Department of Human Resources statewide database regarding child abuse and neglect that may not show up on a Maryland or FBI criminal background check.
- 2. Who must sign the Child Protective Services Background Clearance form if the employee is a minor?**
 - a. DHR/Social Services will accept the form signed by a minor, who is 16 years old or older, without a parent legal guardian signature.
 - b. DHR/Social Services will only accept the form from a minor, who is 15 years old or younger, if both the minor and the parent or guardian signs the form.
- 3. Why must the Child Protective Services Background Clearance form be notarized?**
 - a. The form must be notarized because it is a legal document giving Child Protective Services the ability to release the requested information to the person or entity listed on the form.
- 4. Why does the Child Protective Services Background Clearance form request information on race, sex and birthdate for my children?**
 - a. Information on race, sex and birthdate are used to complete an accurate cross-reference search of the database. If you have questions regarding this matter you may contact Patricia Walker at 410-767-8821.
- 5. Can I refuse to answer questions on the form?**
 - a. No. All questions on the form must be completed or the form will not be processed.

6. Why are there two forms on the “Most Requested Forms and Documents” webpage?

- a. There are two different forms on the webpage because one form is only to be used by the personnel administrator at the camp, while the other form is to be used by all other employees. The results of these two forms go to two different places. Results for the personnel administrator are returned to DHMH, while the results for employees are returned to the camp personnel administrator.

7. What if I don’t have results back from Child Protective Services by the time camp starts?

- a. Prior to sending the notarized copy of the Child Protective Services Background Clearance form to Social Services, make and store a copy of the document in the employee’s personnel file. DHMH will accept this copy as good faith that the personnel administrator has sent the form to be processed by Social Services.

8. How often does an employee have to complete this form?

- a. Each employee is only required to complete this form once as long as the camp personnel administrator maintains the results of the Child Protective Services Background Clearance on file.

9. Do employees from out-of-state or another country need to complete the Child Protective Services Background Clearance form?

- a. Yes. All employees must complete this form in order to work at a youth camp in Maryland, also see question 11

10. Are volunteers required to complete the Child Protective Services Background Clearance form?

- a. No. Volunteers are not required to complete the Child Protective Services Background Clearance form. However, camp may require volunteers to complete form if they wish. The DHMH recommends that volunteers complete the same background clearance process as employees since volunteers will have access to children.

11. The instructions indicate that it is sent to a local Social Services office, where do I mail the form?

- a. Youth Camps are to mail their Child Protective Services Background Clearance forms to:

Department of Human Resources
 In-Home Services
 Social Services Administration
 311 W Saratoga Street, Room 553
 Baltimore, MD 21202

12. What do I do if information is found in the Child Protective Services database?

- a. The camp personnel administrator must assess the suitability for employment of the individual based on the criteria listed in COMAR 10.16.06.21F, which says:

“F. If, as reported on or after October 1, 2005, an individual has been identified as responsible for child abuse or neglect or received a conviction, a probation before judgment disposition, a not criminally responsible disposition, or a pending charge for the commission or attempted commission of a crime or offense that is not included in §E of this regulation, the operator:

- (1) Shall assess, on the basis of the following factors, the individual's suitability for employment:
 - (a) The job position at the camp for which the individual is applying or for which the individual is currently employed;
 - (b) The nature and seriousness of the incident, crime, or offense;
 - (c) The period of time that has elapsed since the incident, crime, or offense occurred;
 - (d) The age of the individual at the time the incident, crime, or offense occurred;
 - (e) The individual's probation or parole status, if applicable; and
 - (f) Any other information the camp considers pertinent; and
- (2) Depending on the results of the assessment, shall permit or prohibit employment of the individual.”

13. Can a person who is found unsuitable to be employed at the camp volunteer at the camp?

- a. No, according to COMAR 10.16.06.21, once the personnel administrator determines that the person cannot be employed to work at camp because of the criminal or Child Protective Services results the person cannot then volunteer at camp.

EMERGENCY PROCEDURES

Emergency Plan

Purpose

The purpose of a written emergency plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while at camp.

Training

Staff and volunteers must receive training in the emergency plan. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's emergency procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the emergency procedures.

Availability

A copy of the emergency plan must be available to the camp staff. The emergency plan must be on file in the headquarters or office of the camp.

- Where are copies of the written emergency plan kept?
- Do staff/volunteers receive a copy?

Writing Emergency Procedures:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. How do you monitor for severe weather?
2. When severe weather or other emergencies happen where do campers go to be safe?
3. How would campers and staff members evacuate the camp? (i.e. buses or cars)
4. Where would everyone go?
5. How do you account for all campers? (i.e. daily roster for whole camp, daily roster for each group, buddy system)
6. What are the procedures your staff members follow for locating a missing camper?
7. For each group of campers, the operator must have a minimum of two staff present. At least one staff member must be an adult. In the event of an emergency, who remains with an injured camper and who summons emergency assistance?
8. Where is a phone that can be used to dial 911 located?
9. Do senior staff members have cell phones or radios?

10. Who is responsible for calling 911?
11. How do you contact emergency services if the telephone is not working?
12. What is available for transporting campers and staff members in an emergency?
13. How would you notify parents of what is happening at camp regarding an emergency?
14. How does the camp receive emergency communication?
15. Where would parents pick up the campers if camp needed to be evacuated?
16. When are drills in the emergency procedures practiced with campers? Drills are required at the beginning of each session or anytime new campers are added.
17. Do you have a form to document the date, time, and outcome of each practice drill?

TRIP AND TRANSPORTATION

Trip Safety Plan

Purpose

The purpose of a written trip safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while on a trip.

Training

Staff and volunteers must receive training in the trip safety plan. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's trip safety plan.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the trip safety plan.

Availability

A copy of the trip safety plan must be available to the camp staff. The trip safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the written trip safety plan kept?
- Do staff/volunteers receive a copy?

Writing Trip Safety Plan:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. What are the potential health and safety risks for the trip?
2. How are the potential health and safety risks for the trip addressed?
3. What are the qualifications of the camp staff members for the trip?
4. What are the responsibilities of the camp staff members for the trip?
5. How are parents or guardians, campers, staff members and volunteers informed about the trip before campers or staff members participate in the trip?
6. How is written authorization from the camper's parent or guardian obtained before the camper participates in the trip?
7. What are the participation eligibility requirements for the trip?
8. What are the supervision requirements for the trip? Include camper to staff ratios (Minimum 10 campers to 1 adult).
9. What are the safety rules, standards, and practices for the trip?

10. Is there any equipment that will be used during the trip? If so, explain what it is, how it is to be maintained, and where it is to be stored. **71**
11. How, when, and where are campers', staff members', and volunteers' health and emergency information maintained during the trip?
12. What form of emergency communication is available on the trip?
13. Who is the designated contact person on the trip?
14. How is attendance taken on the trip?
15. Is the director or director's designee present on the trip?
16. How will the camp contact person maintain the following:
- A roster of participants?
 - Departure and return times?
 - Attendance during the:
 - Departure?
 - Activity?
 - Return?
 - An itinerary?
 - The route taken?
 - Inclement weather plans?
17. How will the camp operator ensure that:
- A camper is instructed in the trip safety plan and use of any protective equipment?
 - A camper, staff member, or volunteer is provided with and uses safety equipment suitable to the trip?
 - The trip is conducted according to the safety plan?

Transportation Safety Plan

Purpose

The purpose of a written transportation safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while being transported.

Training

Staff and volunteers must receive training in the transportation safety plan. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's transportation safety plan.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the transportation safety plan.

Availability

A copy of the transportation safety plan must be available to the camp staff. The transportation safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the written transportation safety plan kept?
- Do staff/volunteers receive a copy?

Writing Transportation Safety Plan:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. Is transportation provided according to applicable State laws?
2. What are the transportation safety rules, standards and practices?
3. What are the supervision requirements during transportation? Include camper to staff member ratios.
4. What are the emergency transportation services should the need arise?
5. What are the severe weather procedures while being transported?
6. What safety equipment is provided and used? (i.e. car seats for younger children, seat belts)
7. Is the driver an adult?
8. Is the driver licensed according to applicable State law?
9. The number of occupants in the vehicle may not exceed the vehicle manufacturer's seating capacity. How will the camp operator ensure that this will be followed?

10. How will camp obtain written authorization from a camper's parent or guardian for the camper to be transported? **73**

11. How is vehicular traffic controlled on the campsite?

12. When there are 10 or more campers in a vehicle, how will camp ensure that in addition to the driver that there is another assistant counselor or adult on duty and supervising the campers?

13. How will the camp operator ensure that staff members and volunteers understand that campers are not to be transported in non-passenger vehicles, an individual's care without obtaining written authorization from the camper's parent or guardian and the owner of the vehicle?

If camp provides transportation to camp, from camp or to and from camp include the answers to the following questions in your transportation safety plan:

14. Is the director available for consultation?

15. How will the following written information be provided to the camper's parent or guardian:

- Camper's pick-up time and designated pick-up location?
- Camper's drop-off time and designated drop-off location?
- Camp's pick-up and drop-off safety procedures?
- Camp's policy concerning the camp's responsibility for supervising a camper when the camper is picked up, dropped off, and transported?

16. How will camp obtain a written agreement from the camper's parent or guardian concerning the parent's or guardian's responsibility for supervising a camper before the camper is picked up and after the camper is dropped off?

SUPERVISION

Supervision of Campers during Routine Activities Chart
COMAR 10.16.06.54

Instructions: Determine the age of the youngest camper within the group, find that age on the chart. Then determine the number children in the group and use those supervision ratios for the group.

Example: If my group has campers that are 4 years old to 7 years old, I would use the blue section for 3 ½ to 5 years old. Since I have 10 campers in my group I determine that I need 1 adult and another adult or assistant counselor to meet the routine supervision ratios required by this regulation.

Campers	Required Number of Adults and Assistant Counselors	
	Adults	Assistant Counselors or Adults
3 ½ to 5 years old		
1 to 8	1	0
9 to 16	1	1
17 to 24	1	2
6 to 10 years old		
1 to 15	1	0
16 to 30	1	2 or
	2	0
11 years old or older		
1 to 15	1	0
16 to 30	1	2 or
	2	0
31 to 40	2	2 or
	3	0

CHILD ABUSE PREVENTION AND REPORTING

Child Abuse Prevention and Reporting Program

Purpose

The purpose of a written child abuse prevention and reporting program is to inform camp staff and volunteers what actions to follow to ensure camper's safety while at camp.

Training

Staff and volunteers must receive training in the child abuse prevention and reporting program. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's child abuse prevention and reporting program.

- Describe the training: what/where/when. Document that each staff member/volunteer was trained before camp and knows the child abuse prevention and reporting program.

Availability

A copy of the child abuse prevention and reporting program must be available to the camp staff. The child abuse prevention and reporting program must be on file in the headquarters or office of the camp.

- Where are copies of the written child abuse prevention and reporting program kept?
- Do staff members/volunteers receive a copy?

Writing Child Abuse Prevention and Reporting Program:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. When, where, and how are staff members and volunteers educated on the child abuse?
2. What are the internal and external steps to reporting suspected child abuse?
3. How are staff members and volunteers screened prior to working at camp? (i.e. required background checks, CPS clearances, interviews, reference checks, etc.)
4. How do staff members and supervisors reinforce the camp's policies and procedures related to child abuse prevention during camp operation? (i.e. camp's code of conduct, training and monitoring, etc.)
5. Who evaluates the facilities and grounds related to child abuse prevention?
6. What areas of the facility or grounds are high risk areas?
7. What precautions are taken to limit exposure to or time in high risk areas?
8. What is the camp's staffing and supervision structure? (i.e. ratios of staff to campers, procedures for limiting one on one interactions, open door policy, etc.)

9. How are staff members, volunteers and campers educated about the camp's policy on appropriate touching? **78**
10. What is camp's policy for dealing with inappropriate behaviors by:
- Staff members/volunteers?
 - Parents?
 - Campers?
11. Who will communicate with:
- Staff members and volunteers?
 - Campers and parents?
 - The Department of Health and Mental Hygiene?
 - The media?
12. How will staff members/volunteers support an alleged victim?
13. How will staff members/volunteers interact with an alleged perpetrator?

While these questions form the minimum requirements of the regulations, the Center for Healthy Homes and Community Services has also made available on its website a self-assessment tool. Please consider using this tool when evaluating your camp with regards to child abuse prevention and reporting.

Child Protective Services

<http://www.dhr.state.md.us/cps>

What is Child Abuse and Neglect?

CODE OF MARYLAND REGULATIONS (COMAR) defines child abuse and child neglect as:

- Physical injury *not necessarily visible* of a child under circumstances that indicate that a child's health or welfare is harmed or at substantial risk of being harmed.
- The failure to give proper care and attention to a child including the leaving a child unattended where the child's health or welfare is harmed or a child is placed in substantial risk of harm.
- An act or acts involving sexual molestation or exploitation whether physical injuries are sustained or not.
- Identifiable and substantial impairment of a child's mental or psychological ability to function.
- Finding credible evidence that has not been satisfactorily refuted that physical abuse, neglect or sexual abuse occurred.

Department of Human Resources
General Information: 1-800-332-6347
TTY: 1-800-332-6347
Numero del telefono directo: 1-800-732-7850
Social Services Administration
(410) 767-7112

Local Departments of Social Services Child Protective Services for the State of Maryland

County	Phone Number & Address
Allegany County	Tel: (301) 784-7122, After hours: (301) 759-0362 FAX: (301) 784-7244 Address: One Frederick Street, Cumberland, Maryland 21502
Anne Arundel County	Tel: (410) 421-8400 FAX: (410) 508-2041 Address: 7500 Ritchie Hywy, Glen Burnie, Maryland 21061-1787
Baltimore City	Tel: (410) 361-2235 (24 hours) FAX: (443) 423-7003 or 7002, After 3:30-hours (443) 423-5950 Address: 1900 N. Howard Street, Baltimore, Maryland 21218
Baltimore County	Tel: (410) 853-3000 (Option 1) After hours: (410) 583-9398 FAX: (410) 853-3698 Address: Drumcastle Government Center, 6401 York Road, Baltimore, Maryland 21212
Calvert County	Tel: 1-443-550-6900, After hours: (Toll Free: 1-800-787-9428) FAX: (410) 286-7429 Address: 200 Duke Street, Prince Frederick, Maryland 20678
Caroline County	Tel: (410) 819-4500, After hours: (410) 479-2515 Sheriff's Office. FAX: (410) 819-4501 Address: 207 South Third Street, Denton, Maryland 21629
Carroll County	Tel: (410) 386-3434 (24 Hours) FAX: (410) 386-3477 Address: 1232 Tech Drive, Westminster, Maryland 21157
Cecil County	Tel: (410) 996-0100 (Option 3), After hours: (410) 996-5350 FAX: (410) 996-0228 Address: 170 East Main Street, Elkton, Maryland 21922-1160

County	Phone Number & Address
Charles County	Tel: (301) 392-6739, After hours: (301) 932-2222 FAX: (301) 934-2662 Address: P.O. Box 1010, 200 Kent Avenue, LaPlata, Maryland 20646
Dorchester County	Tel: (410) 901-4100, After hours: (410) 221-3246 FAX: (410) 901-1060 Address: P.O. Box 217, 627 Race Street, Cambridge, Maryland 21613
Frederick County	Tel: (301) 600-2464, After hours: (301) 600-2100 Police Dept. FAX: (301) 600-2639 Address: 100 East All Saints Street, Frederick, Maryland 21701
Garrett County	Tel: (301) 533-3005, After hours: (301) 334-1930 Sheriff's Office. FAX: (301) 334-5413 Address: 12578 Garrett Highway, Oakland, Maryland 21550
Harford County	Tel: (410) 836-4713, After hours: (410) 838-6600 Sheriff's Office. FAX: (410) 836-4945 Address: 2 South Bond Street, Bel Air, Maryland 21014
Howard County	Tel: (410) 872-4203, After hours: (410) 313-2929 Police Dept. FAX: (410) 872-4303 Address: 7121 Columbia Gateway Drive, Columbia, Maryland 21046
Kent County	Tel: (410) 810-7600, After hours: (410) 758-1101 State Police FAX: (410) 778-1497 Address: 350 High St, Chestertown, Maryland 21620
Montgomery County	Tel: (240) 777-4417 (24 hours) FAX: (240) 777-4258 Address: The Dept. of Health & Human Services, 1301 Piccard Drive Rockville, Maryland 20850
Prince George's County	Tel: (301) 909-2450, After hours: (301) 699-8605 FAX: (301) 909-2200 Address: 805 Brightseat Road, Landover, Maryland 20785
Queen Anne's County	Tel: (410) 758-8000 (all hours), After hours: (410) 758-0770 Sheriff's Office. FAX: (410) 758-8110 Address: 125 Comet Drive, Centreville, Maryland 21617
St. Mary's County	Tel: (240) 895-7016, After hours: (301) 475-8016 FAX: (240) 895-7099 Address: 23110 Leonard Hall Drive, Leonardtown, Maryland 20650
Somerset County	Tel: (410) 677-4200, After hours: (410) 651-9225 Sheriff's Office Centra, Emergency Services. FAX: (410) 677-4300 Address: P.O. Box 369, 30397 Mt. Vernon Road, Princess Anne, Maryland 21853
Talbot County	Tel: (41) 770-4848 (option#1), After hours: (410) 822-3101 MD State Police FAX: (410) 820-7067 Address: 301 Bay Street, Easton, Maryland 21601
Washington County	Tel: (240) 420-2222 (24 hours) FAX: (240) 420-2549 Address: 122 North Potomac Street, Hagerstown, Maryland 21741-1419
Wicomico County	Tel: (410) 713-3900 (option#1), After hours: (410) 548-4891 FAX: (410) 713-3910 Address: 201 Baptist Street, Salisbury, Maryland 21802-2298
Worcester County	Tel: (410) 677-6800, After hours: (410) 632-1111 (option#2) Sheriff's Office. FAX: (410) 677-6810 Address: 299 Commerce Street, Snow Hill, Maryland 21863

From Maryland Department of Human Resources Website (<http://www.dhr.state.md.us/>)

What is Child Abuse and Neglect?

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- The failure to give proper care and attention to a child including the leaving a child unattended where the child's health or welfare is harmed or a child is placed in substantial risk of harm.
- An act or acts involving sexual molestation or exploitation whether physical injuries are sustained or not.
- Identifiable and substantial impairment of a child's mental or psychological ability to function.
- Finding credible evidence that has not been satisfactorily refuted that physical abuse, neglect or sexual abuse occurred.

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COUNTY	PHONE NUMBER & ADDRESS
Charles County	Tel: (301) 392-6739, After hours: (301) 932-2222 FAX: (301) 934-2662 Address: P.O. Box 1010, 200 Kent Avenue, LaPlata, Maryland 20646
Dorchester County	Tel: (410) 901-4100, After hours: (410) 228-2222 FAX: (410) 901-1060 Address: P.O. Box 217, 627 Race Street, Cambridge, Maryland 21613
Frederick County	Tel: (301) 600-2464, After hours: (301) 600-2100 Police Dept. FAX: (301) 600-2639 Address: 100 East All Saints Street, Frederick, Maryland 21701
Garrett County	Tel: (301) 533-3005, After hours: (301) 334-1930 Sheriff's Office. FAX: (301) 334-5413 Address: 12578 Garrett Highway, Oakland, Maryland 21550
Harford County	Tel: (410) 836-4713, After hours: (410) 838-6600 Sheriff's Office. FAX: (410) 836-4945 Address: 2 South Bond Street, Bel Air, Maryland 21014
Howard County	Tel: (410) 872-4203, After hours: (410) 313-2929 Police Dept. FAX: (410) 872-4303 Address: 7121 Columbia Gateway Drive, Columbia, Maryland 21046
Kent County	Tel: (410) 810-7600, After hours: (410) 758-1101 State Police FAX: (410) 778-1497 Address: 350 High St, Chestertown, Maryland 21620
Montgomery County	Tel: (240) 777-4417 (24 hours) FAX: (240) 777-4258 Address: The Dept. of Health & Human Services, 1301 Piccard Drive Rockville, Maryland 20850
Prince George's County	Tel: (301) 909-2450, After hours: (301) 699-8605 FAX: (301) 909-2200 Address: 805 Brightseat Road, Landover, Maryland 20785
Queen Anne's County	Tel: (410) 758-8000 (all hours), After hours: (410) 758-0770 Sheriff's Office. FAX: (410) 758-8110 Address: 125 Comet Drive, Centreville, Maryland 21617
St. Mary's County	Tel: (240) 895-7016, After hours: (301) 475-8016 FAX: (240) 895-7099 Address: 23110 Leonard Hall Drive, Leonardtown, Maryland 20650
Somerset County	Tel: (410) 677-4200, After hours: (410) 651-9225 Sheriff's Office Centra, Emergency Services. FAX: (410) 677-4300 Address: P.O. Box 369, 30397 Mt. Vernon Road, Princess Anne, Maryland 21853
Talbot County	Tel: (41) 770-4848 (option#1), After hours: (410) 822-3101 MD State Police FAX: (410) 820-7067

COUNTY	PHONE NUMBER & ADDRESS
	Address: 301 Bay Street, Easton, Maryland 21601
Washington County	Tel: (240) 420-2222 (24 hours) FAX: (240) 420-2549 Address: 122 North Potomac Street, Hagerstown, Maryland 21741-1419
Wicomico County	Tel: (410) 713-3900 (option#1), After hours: (410) 548-4891 FAX: (410) 713-3910 Address: 201 Baptist Street, Salisbury, Maryland 21802-2298
Worcester County	Tel: (410) 677-6800, After hours: (410) 632-1111 (option#2) Sheriff's Office. FAX: (410) 677-6810 Address: 299 Commerce Street, Snow Hill, Maryland 21863

Maryland Department of Health and Mental Hygiene

Center for Healthy Homes and Community Services

Child Abuse Prevention and Reporting Self-Assessment Tool

This self-assessment tool is designed to assist youth camp operators in developing a child abuse prevention and reporting plan. The self-assessment tool will walk you through the various questions and strategies needed to create a safer space for your campers. The goal is to increase your camp's strengths while decreasing the risks that are inherent within a youth camp.

If you find that you have answered "yes" to all of the questions in a section, congratulations. Celebrate what you have already accomplished as well as the protections you have already put into place. If you answered "no" to some questions it does not mean that you should immediately develop a new policy or procedure. Rather, this process will help you look at your camp's mission, programs, and resources and decide what makes the most sense for your camp today. It will also help you identify your next steps as you plan for what may be possible for the next 3-5 years.

After you have completed the survey, review what you have in place (your protective factors) and then decide as a camp, what strategies you may want to consider as you strengthen your camp. Remember, do not try to create more policies or procedures than you have the resources to realistically put into place. It is better to start small and then add along the way as resources or compelling reasons emerge.

Finally, as you go through each question, you do not have to do this alone. You may want to create a review team or ask a few staff members to help in different areas. If you have any questions about the process, please do not hesitate to contact the Center for Healthy Homes and Community Services at 410-767-8417.

55 Camp Name: 88

EDUCATE

For Employees

#	Question	Yes	No	Unsure	N/A
1	Are child abuse prevention policies included in the orientation of new employees?				
2	Do you train all employees about child abuse and how to recognize the indicators of abuse?				
3	Are employees trained in how to respond to an adult's inappropriate behaviors toward children?				
4	Are employees trained in how to respond to inappropriate behaviors between children and between adolescents?				
5	Are employees trained on the legal requirements for reporting and responding to allegations of child abuse?				

For Volunteers

6	Are child abuse prevention policies included in the orientation of new volunteers?				
7	Do you train all volunteers about child abuse and how to recognize the indicators of abuse?				
8	Are volunteers trained in how to respond to an adult's inappropriate behaviors towards children?				
9	Are volunteers trained in how to respond to inappropriate behaviors between children and between adolescents?				
10	Are volunteers trained on the legal requirements for reporting and responding to allegations of child abuse?				

For All

11	Do you provide access to free materials and online courses to educate program staff, volunteers and all agency employees about child abuse, especially if they are unable to attend orientation or training?				
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RESPONDING (REPORTING)

#	Question	Yes	No	Unsure	N/A
12	Is your organization familiar with the laws pertaining to child abuse (e.g., mandated reporting laws, process of reporting, etc.)?				
13	Does your organization have a person or committee responsible for confronting any sexual or other misconduct by staff?				
14	Does your organization have a person or committee responsible for reporting allegations of child abuse?				
15	Is there a clear policy and protocol in place for how to report an allegation of child abuse?				
16	Has your organization contacted the county child protection services to confirm the correct reporting procedures?				
17	Do you have specific insurance requirements related to child abuse that you need to incorporate into your policies and procedures?				

PREPARE (SCREEN)

Do you have a basic application and screening process that includes:

18	A written application?				
19	Face to face interviews?				
20	At least three professional (or personal) reference checks?				
21	An internet search?				
22	A criminal background check?				
23	A sex offender registry check?				
24	A child protective services background clearance check?				

#	Question	Yes	No	Unsure	N/A
25	Do you ask any questions during the interview process that specifically addresses child abuse prevention?				
REINFORCE					
26	Do you review your policies to ensure that they are up to date annually?				
27	Is there a regular (e.g., annual) review with staff members of any change in child abuse prevention policies (e.g., in a staff meeting or by a formal training) to ensure that employees are aware of these changes? Review for staff members even if no change?				
28	Does formal supervision address appropriate and inappropriate behaviors with children and between children (e.g. boundaries, touching, etc.)?				
29	Does informal supervision exist within the organization (e.g., time for supervisor to drop in on activities)?				
30	If an issue has been identified and behavior is being monitored, has documentation also occurred?				
FACILITY AND GROUNDS					
Visibility					
31	Are there windows on all doors or an open door policy when meeting with children or teens?				
32	Is there adequate lighting in all rooms?				
33	Are isolated areas off limits for youth?				
34	Are all isolated areas closed, locked and secured?				
35	In larger facilities, are there operating cameras in less frequented areas?				

Building Usage					
#	Question	Yes	No	Unsure	N/A
36	Is there a clearly defined building usage strategy to minimize unsupervised access to children and youth in the program?				
37	Are there clear physical boundaries of the organization's space (e.g., when the organization is responsible and when the caregivers are responsible)?				
38	Is there clear signage to ensure that people know where to go for various activities?				
39	Are programs that may present a threat to children and youth clearly separated from the children's space? (e.g., in a multi-disciplinary agency, are the services for children kept in a different part of the building than the space for homeless men and women)?				
Administration					
40	Is there an emergency phone accessible to staff, children and youth?				
41	Is access to children and youth addresses and contact information closely monitored and not released to any unauthorized individuals?				
SAFETY POLICIES					
Entry and Exits					
42	Do procedures exist for welcoming and departing children and youth?				
43	Do procedures ensure that children and youth are monitored during transitions from one activity to another?				
44	Do procedures exist for entry and exiting of parents, guardians, and guests?				
45	Do you have a clear policy for parents to drop in to observe or participate in activities?				
46	Are all entrances and exits clearly supervised (if not locked at all times)?				

Offsite Trips					
#	Question	Yes	No	Unsure	N/A
47	Are there guidelines for obtaining caregiver permission for offsite trips?				
48	Are there guidelines for transporting children and youth for offsite trips?				
49	Are there guidelines for overnight stays during offsite trips?				
Supervision					
50	Are there guidelines for certain high risk activities (e.g., toileting for young children)?				
51	If yes, are the guidelines age appropriate?				
52	Is there a designated observer (someone who ensures that the policies and procedures of the organization are carried out) to ensure all children are adequately supervised?				
53	Are adults allowed to have one-on-one contact with children (e.g., a mentor relationship, big brother, etc.)?				
54	If yes, are there regular contacts, group supervision, etc. to monitor this one-on-one contact?				
55	Are there set ratios of employee/volunteer to children/youth?				
56	Do you have process to ensure that these protocols are followed?				
57	Is teen access to children limited or very well supervised (e.g., teens are never put in the position of sole leadership of younger children)?				
SAFETY POLICIES					
58	Is there a clear procedure or guideline for responding to inappropriate behaviors toward children and youth by staff members?				
59	Is there a clear procedure or guideline for responding to inappropriate behaviors between children and youth?				

#	Question	Yes	No	Unsure	N/A
60	Are there clear guidelines for appropriate touch in the organization?				
COMMUNICATIONS AND HEALING					
61	Is one person assigned to talk with the media, staff members, youth or families involved if/when an allegation is made against an employee, volunteer, or child/youth participating in the organizational activities?				
62	Is there a person (could be same person) assigned to talk with the media, staff members, youth or families involved when a case of child abuse is uncovered in a participant's family?				
63	Is there a policy or protocol on how to support the alleged victim once an allegation has been made?				
64	Is there a policy or protocol about how to deal appropriately with the alleged perpetrator (adult, teen, or child) once an allegation of child abuse has been made?				

This "Self-Assessment Tool" was adapted from a tool developed in 2008 by Enough Abuse Campaign Consultant Joan Tabachnick and the Massachusetts Child Sexual Abuse Prevention Partnership's Youth-Serving Organizations' Work Group.

FACILITIES

LOCAL HEALTH APPROVAL

For Youth Camp locations that have an On-Site Well,
On-Site Sewage Disposal, Portable Toilets, or Privies

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 Fax (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

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CAMP OPERATOR

If your youth camp facility has an on-site water supply and/or sewage disposal system, annual approval from the local environmental health department is required. **Complete the information in this section and forward the form, 90 days before the camp operates, to the appropriate local environmental health department on page 2.**

If your camp operates at a school (public or private) or a government owned building or park that is used by the public more than 170 days per year, use the Building Safety form, instead of this form.

CAMP OPERATOR NAME	PHONE	FAX
CAMP NAME	DATES OF OPERATION	CAMP OCCUPANCY
MAILING ADDRESS	SITE ADDRESS	
CITY STATE ZIP	CITY STATE ZIP	

LOCAL HEALTH DEPARTMENT

The operator is seeking a youth camp certificate or letter of compliance from the Department of Health and Mental Hygiene, Center for Healthy Homes and Community Services for the above referenced camp. The water supply and/or sewage disposal system is on-site and requires approval from your Office. **Complete the information below, sign, and return the form to the camp operator listed above.**

WATER SUPPLY

- Indicate type of on-site water supply. ☐ Individual water supply system.
☐ Public transient noncommunity water supply system. ☐ Public nontransient noncommunity water supply system.

➤ Indicate if the water supply is adequate, easily accessible to the campers, of a safe and sanitary quality and from an approved water supply system which is constructed, protected, operated and maintained in conformance with COMAR 26.04.01, 26.04.04 and applicable local subdivision ordinances.

- ☐ APPROVED ☐ DISAPPROVED Please notify the Center for Consumer Health Services of the violation(s) and corrective action. ☐ NOT APPLICABLE

Date of last sample(s)

Remarks: _____

SIGNATURE	TITLE	DATE	PHONE
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SEWAGE DISPOSAL SYSTEM

➤ Indicate if the on-site sewage disposal system is installed, operated, and maintained in compliance with COMAR 26.04.02. ☐

- ☐ APPROVED ☐ DISAPPROVED Please notify the Center for Consumer Health Services of the violation(s) and corrective action. ☐ NOT APPLICABLE

System Capacity
(# persons) _____

- Indicate if portable toilets are permitted. ☐ YES # _____ ☐ NO ☐ NOT APPLICABLE
If yes, is a maintenance agreement with an approved scavenger in place? ☐ YES ☐ NO

➤ Indicate if a privy is constructed and maintained so that it is fly-proof and rodent proof and conforms to COMAR 26.04.02 and Environment Article, Section 9-223(d)(1), Annotated Code of Maryland.

- ☐ APPROVED ☐ DISAPPROVED Please notify the Center for Consumer Health Services of the violation(s) and corrective action. ☐ NOT APPLICABLE

Remarks: _____

SIGNATURE	TITLE	DATE	PHONE
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LOCAL ENVIRONMENTAL HEALTH DEPARTMENTS

Allegany County Health Dept.
Environmental Health Division
P.O. Box 1745
Cumberland, Maryland 21501-1745
Telephone (301) 759-5040
Fax Number (301) 777-5583

Anne Arundel Co. Health Dept.
Division of Environmental Health
3 Harry S. Truman Parkway
Annapolis, Maryland 21401
Telephone (410) 222-7180
Fax Number (410) 222-7678

Baltimore City Bureau of Environmental Health
1001 E Fayette St
Baltimore, Maryland 21202
Telephone (410) 396-4424
Fax Number (410) 396-5986

Baltimore County Environmental
Protection & Resource Management
111 W Chesapeake Ave, Ste 319
Towson, Maryland 21204-4420
Telephone (410) 887-3733
Fax Number (410) 887-4804

Calvert County Health Department
Environmental Health Division
P.O. Box 980
Prince Frederick, Maryland 20678
Telephone (410) 535-3922
Fax Number (410) 535-5252

Caroline County
Division of Environmental Health
403 S 7th Street- Room 248
Denton, Maryland 21629
Telephone (410) 479-8045
Fax Number (410) 479-4082

Carroll County Health Department
Bureau of Environmental Health
290 S. Center St.
Westminster, Maryland 21158
Telephone (410) 876-1884
Fax Number (410) 876-4430

Cecil County Health Department
Environmental Health Services
401 Bow Street
Elkton, Maryland 21921-5515
Telephone (410) 996-5160
Fax Number (410) 996-5153

Charles County Health Department
Environmental Health Services
4545 Crain Highway
White Plains, Maryland 20695
Telephone (301) 609-6751
Fax Number (301) 609-6684

Dorchester County Health Department
Environmental Health Division
3 Cedar Street
Cambridge, Maryland 21613
Telephone (410) 228-1167
Fax Number (410) 901-8192

Frederick County Health Department
Environmental Health Services
350 Montevue Lane
Frederick, Maryland 21702
Telephone (301) 600-1719
Fax Number (301) 600-3180

Garrett County Health Department
Environmental Health Services
1025 Memorial Drive
Oakland, Maryland 21550
Telephone (301) 334-7760
Fax Number (301) 334-7769

Harford County Bureau of
Environmental Health
120 S. Hays Street Ste 200
Bel Air, Maryland 21014-0191
Telephone (410) 877-2300
Fax Number (443) 643-0333

Howard County Health Department
8930 Stanford Blvd
Columbia, Maryland 21045
Telephone (410) 313-1771
Fax Number (410) 313-2648

Kent County Environmental Health
125 S. Lynchburg St.
Chestertown, Maryland 21620
Telephone (410) 778-1361
Fax Number (410) 778-7017

Montgomery County
License and Regulatory Services
255 Rockville Pike Suite 120
Rockville, Maryland 20850
Telephone (240) 777-3986
Fax Number (240) 777-7765

Prince George's County Health
Department/Environmental Health
9201 Basil Court, Suite 318
Largo, Maryland 20774
Telephone (301) 883-7605
Fax Number (301) 883-7601

Queen Anne's County Health Department
Environmental Health Section
206 North Commerce Street
Centreville, Maryland 21617
Telephone (410) 758-2281
Fax Number (410) 758-6602

Somerset County Health Department
7920 Crisfield Highway
Westover, Maryland 21871
Telephone (443) 523-1730
Fax Number (410) 651-4083

St. Mary's County Office
of Environmental Health
21580 Peabody Street-P.O. Box 316
Leonardtown, Maryland 20650
Telephone (301) 475-4321
Fax Number (301) 475-4373

Talbot County Health Department
215 Bay Street- Suite 4
Easton, Maryland 21601
Telephone (410) 770-6880
Fax Number (410) 770-6888

Washington County Environmental Health
13332 Pennsylvania Avenue
Hagerstown, Maryland 21742
Telephone (240) 313-3400
Fax Number (240) 313-3424

Wicomico County Health Department
Environmental Health
108 East Main Street
Salisbury, Maryland 21801
Telephone (410) 546-4446
Fax Number (410) 219-2882

Worcester Co Health Department
Office of Environmental Health
13070 St Martin's Neck Rd
Bishopville, Maryland 21813
Telephone (410) 352-3234
Fax Number (410) 352-3369

BUILDING SAFETY

For Youth Camps using a School (Public or Private)
or a Government Owned Building or Property

Department of Health & Mental Hygiene (DHMH) **94**
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. CAMP OPERATOR

If your youth camp is operating at a school (public or private) or a government owned building or property that is used by the public more than 170 days, complete the information in this section and forward this form to the building owner or the building owner's authorized representative.

CAMP OPERATOR NAME			PHONE	
CAMP NAME		SITE OWNER		
MAILING ADDRESS		SITE ADDRESS		
CITY	STATE	ZIP	CITY ZIP	STATE

II. BUILDING OWNER

This facility is seeking a youth camp certificate or letter of compliance from the Department of Health and Mental Hygiene, Center for Healthy Homes and Community Services. Please complete the information below, and return the form to the camp operator listed above.

- ☐ The water supply is adequate, easily accessible to the campers, of a safe and sanitary quality and from an approved water supply system which is constructed, protected, operated and maintained in conformance with applicable State codes and local subdivision ordinances.
- ☐ The sewage disposal system is installed, operated, and maintained in conformance with applicable State codes and local subdivision ordinances.
- ☐ The plumbing at this building is installed, protected and maintained in conformance with applicable State codes and local subdivision ordinances.
- ☐ The electrical system at this building is installed and maintained in conformance with applicable State codes and local subdivision ordinances.
- ☐ The building is constructed and maintained in conformance with all fire and safety code requirements and is approved by the State or county fire authority.
- ☐ The building or property meets applicable local building and zoning approvals.

The camp operator should be aware of the following problems.

Water Supply: _____

Sewage Disposal: _____

Plumbing: _____

Electrical: _____

Fire Safety: _____

Zoning: _____

Other: _____

BUILDING OFFICIAL'S SIGNATURE	TITLE	DATE	PHONE
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HEALTH PROGRAM

Health Program

Purpose

The purpose of a written health program is to inform camp staff and volunteers what actions to follow to ensure each camper's health and safety while at camp.

Training

Staff and volunteers must receive training in the health program. Training must include an opportunity to discuss the program and ask questions.

- Describe the training: what/where/when. Explain how you will document that each staff member or volunteer was trained before camp and knows the health program.

Knowledge and Conduct

Staff and volunteers must know and follow the health program procedures.

Availability

A copy of the health program must be available to the camp staff. The health program must be on file in the headquarters or office of the camp.

- Where are copies of the health program kept?
- Do staff/volunteers receive a copy?

Health Supervisor

A health supervisor is a physician, certified nurse practitioner or registered nurse who provides health services for a camp. He/she must be licensed to practice in Maryland. The health supervisor may be a registered nurse licensed in another state if that state is on the list of Compact States. For a list of Compact States see the attached list or for the most current list see the Maryland Board of Nursing website at <http://www.mbon.org>.

- A health supervisor approves the health program annually by signing and dating the written program.
- Provide the printed name, title, license number, and state where the license is held of the camp's health supervisor on the signature page.
- Provide telephone/beeper numbers/address or other information on how to reach the health supervisor.

During camp hours, a health supervisor must be available for consultation. If your camper population consists of 50% or more campers with identified medical problems as defined in COMAR 10.16.07.02B(18), a health supervisor must be on site while camp is in operation.

Writing Health Program Procedures

Answer each question by describing your procedures or the actions you want your staff members to take:

1. How do you obtain Camper and Staff health information?
2. Who reviews the health information?

3. When a camper's health form indicates an identified medical problem as defined in COMAR 10.16.07.02B(18), who contacts the camp's Health Supervisor to create a Plan of Action to deal with the day-to-day needs and medical emergencies of the camper? **97**
4. How is camper health information shared with staff members that need to know?
5. How is confidential health information protected?
6. Who is responsible for being aware of any campers with easily discernable signs of injury or illness?
7. Do you provide any information on disease, illness or injury?
8. How do you handle emergencies and accidents?
9. Who has first aid training?
10. Who calls an ambulance or 911?
11. Who will care for and supervise an injured or ill camper until picked up by parent?
12. Do you have a health treatment area?
13. Who will notify a parent when a camper is injured or ill and how is this done?
14. Who will report camper injuries and illnesses to the camp's Health Supervisor and Maryland Department of Health and Mental Hygiene? Follow the attached chart.
15. Infectious disease prevention:
 - a. When are staff members required to wash their hands?
 - b. When is personal protective equipment required?
 - c. What is the camp's standard for personal hygiene?
 - d. Does the camp have an exposure control plan?
16. Who is the Health Supervisor? Remember to include the name, title, license number and State license held in of the camp's health supervisor.
17. How can the Health Supervisor be contacted? Provide telephone/beeper numbers/address or other information on how to reach the camp's health supervisor.
18. Is the Health Supervisor on-site if 50% or more campers have identified medical problems as defined in COMAR 10.16.07.02B(18)?
19. Is the signature page included? Each year the camp's Health Supervisor must sign and date that they have approved the camp's Health Program.
20. Keep the original Health Program on file at camp headquarters/office.
21. Make sure the Health Program is available to staff members while the camp is operating.

22. Ensure that all health forms are retained for 3 years. This includes the following forms:

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- a. Incident Report Form
- b. Medication Administration Authorization Form
- c. Medication Administration Form
- d. Medication Final Disposition Form

Camper Medication Administration

23. How will the camp operator obtain written authorization from both the parent/guardian and the prescriber? (Indicate use of DHMH-4758, Medication Administration Authorization Form or your form. If using your own form, see question 44 below.)

24. How will the camp operator ensure that, except at a primitive camp, if an emergency medication or while a medication is being administered, medications are kept in a locked storage compartment?

25. How will the camp operator ensure that a prescription medication is kept in the original container bearing a pharmacy label that includes the:

- (a) Prescription number;
- (b) Date filled;
- (c) Authorized prescriber's name;
- (d) Patient's name;
- (e) Name of the medication;
- (f) Dose of the medication;
- (g) Route of administration for the medication;
- (h) Time or frequency of administration for the medication; and
- (i) Expiration date;

26. How will the camp operator ensure that nonprescription medications are kept in an original container that includes the directions for use?

27. How will the camp operator ensure that medication is given to the camper from the original container?

28. How will the camp operator ensure that the directions provided in the prescriptive order for the medication found on the Medication Administration Authorization Form or the standing order are followed?

29. How will the camp operator ensure that the staff member or designated volunteer administering the medication or supervising a camper who is self-administering medication knows the side effects and toxic effects of the medication?

30. How will the camp operator ensure that medication is kept in a secure manner?

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31. How will the camp operator ensure that emergency medications are handled according to the following:

(1) Except as allowed in COMAR 10.16.07.15, an operator shall ensure that:

(a) Emergency medication is:

- (i) Carried by the camper needing the medication if authorized by both the parent or guardian and a licensed or authorized prescriber to self-carry the medication;
- (ii) Carried by an adult staff member or volunteer directly supervising the camper; or
- (iii) Stored at a designated easily accessible location; and

(b) Emergency medication is administered by:

(i) The camper so long as the camper is capable and authorized by both the parent or guardian and a licensed or authorized prescriber to self-administer the medication;

(ii) An adult staff member or volunteer meeting the following requirements:

I. A licensed or certified professional:

[a] Who is authorized to practice in Maryland; and

[b] Whose scope of practice includes medication administration; or

II. An adult staff member or a volunteer who:

[a] Is designated by the operator; and

[b] On an annual basis successfully completes a training course approved annually by the Department; or

(iii) An adult staff member or volunteer trained by a health supervisor.

(2) An operator may allow a camper to self-carry an emergency medication if both the parent or guardian and a licensed or authorized prescriber have provided written consent for the camper to self-carry the emergency medication.

32. How will the camp operator ensure that the medication is stored according to the manufacturer's directions?

33. How will the camp operator ensure that a staff member or designated volunteer documents medication administration on a Medication Administration Form? (Indicate use of DHMH-4759, Medication Administration Form or your form. If using your own form, see question 45 below.)

34. How will the camp operator ensure that a staff member of designated volunteer documents the ~~For~~¹⁰⁰ disposition of the medication on a Medication Final Disposition Form? (Indicate use of DHMH-4760, Medication Final Disposition form or your form. If using your own form, see question 46 below.)
35. How will the camp operator ensure that within 2 weeks after the end of the camping session or when the medication is discontinued, the medication is:
- a. Returned to:
 - i. The parent;
 - ii. The guardian;
 - iii. An individual designated by the parent or guardian who has authorization to pick-up the camper and the medication;
 - iv. Camper, if authorized by the parent or guardian to take their medication with them at the end of the camping session; or

b. Destroyed

36. What is camp's policy on handling medication? (staff administration, camper self-administration or a combination of both)
37. Who administers medications if utilizing staff administration or who is the staff member / volunteer designated to supervise camper self-administration at camp?
38. Is the individual administering medication licensed or trained to do so? (Indicate license or training, such as registered nurse, certified medication technician, or 6-hour medication administration course by Maryland State Department of Education (MSDE))

Staff Member or Volunteer Medication Administration

39. How will the camp operator provide a means to secure medication for a staff member or volunteer when a medication is brought to camp?
40. How will the camp operator ensure that all staff member or volunteer medications are maintained in a secure manner at all times?
41. Will staff members or volunteers self-administer their medication or is there a designated staff member or volunteer that will administer medication to all other staff members or volunteers?
42. If a designated staff member or volunteer will administer medication to all other staff members or volunteers, then:
- c. How will the camp operator ensure that a staff member or volunteer provides written authorization on a medication administration authorization form for each medication brought to camp? (A staff member or volunteer who is an adult may sign their own medication administration authorization form in lieu of a parent or guardian.)

- d. How will the camp operator ensure that the following forms, per medication, are on file for each staff member or volunteer taking medication:
- i. A Medication Administration Authorization Form?
 - ii. A Medication Administration Form?
 - iii. A Medication Final Disposition Form?
- e. How will the camp operator ensure that the forms required above are retained for 3 years and made available to the Department for review?

Electronic Health Records

(Only answer 43 if your camp uses electronic health records.)

43. In the event of a power outage or loss of connection to server, how will the camp operator ensure:
- f. Access to camper, staff and volunteer health information?
 - g. Document injuries, illnesses and other reportable diseases and conditions in a paper health log?
 - h. Document medication administration on a paper form?

Medication Administration Forms

(Only answer 44-46 if your camp uses its own medication administration forms.)

44. If you are using your own medication administration authorization form, does it include the following required pieces: (Include a copy of your form for review)

F(1) The written prescriptive order for the medication that includes:

- (a) The child's name;
- (b) The child's date of birth;
- (c) The condition for which the medication is being administered;
- (d) Whether or not the medication is an emergency medication;
- (e) The name of the medication;
- (f) The dose of the medication;
- (g) The route of administration for the medication;
- (h) The time or frequency of administration for the medication;
- (i) If PRN, the frequency and for what symptoms the medication should be administered;
- (j) The known side effects of the medication specific to the camper;
- (k) The date medication administration shall begin;

- (l) The date medication administration shall end, not to exceed 1 year from the beginning date;
- (m) The authorized prescriber's name;
- (n) The authorized prescriber's title;
- (o) The authorized prescriber's telephone number;
- (p) The authorized prescriber's fax number;
- (q) The authorized prescriber's address;
- (r) The authorized prescriber's signature; and
- (s) The date the form is signed by the authorized prescriber;
- (2) The following statement: "I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA";
- (3) The parent's or guardian's signature;
- (4) The date the parent or guardian signed the form;
- (5) The parent's or guardian's primary phone number;
- (6) The parent's or guardian's alternative phone number;
- (7) If a camp allows a camper to self-administer medication, authorization to self-administer medication that includes:
- (a) The following statement: "I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer";
- (b) The signature of the authorized prescriber and the date the form is signed under the statement in §F(7)(a) of this regulation; and
- (c) The signature of the parent or guardian and the date the form is signed under the statement in §F(7)(a) of this regulation; and
- (8) If a camp allows a camper to self-carry emergency medication, authorization to self-carry emergency medication that includes whether the:

(a) Authorized prescriber gives permission for the child to self-carry emergency medication; and **103**

(b) Parent or guardian gives permission for the child to self-carry emergency medication.

45. If you are using your own medication administration form, does it include the following required pieces:
(Include a copy of your form for review)

- (1) Child's name;
- (2) Child's date of birth;
- (3) Name of the medication;
- (4) Dose of the medication;
- (5) Route of administration for the medication;
- (6) Time or frequency of administration for the medication;
- (7) Amount of medication administered;
- (8) Date and time of administration; and
- (9) Name of the individual who:

(a) Administered the medication to the child; or

(b) Supervised self-administration if the child self-administered the medication.

46. If you are using your own medication final disposition form, does it include the following required pieces: (Include a copy of your form for review)

- (1) The child's name;
- (2) The child's date of birth;
- (3) The name of the medication;
- (4) The final disposition of the medication;
- (5) Documentation that the medication is returned to the parent or guardian, or authorized individual, including the:

(a) Name of the individual to whom the medication was returned; and

(b) Signature of the staff member or volunteer who returned the medication; and

(6) A section for documenting that the medication was destroyed that includes the:

- (a) Signature of the individual responsible for destroying the medication; **104**
- (b) Signature of the individual witnessing the destruction of the medication; and
- (c) Dates each individual signed the form.

**Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camps**

**Health Supervision and Medication Administration
Frequently Asked Questions**

A. Health Supervision

1. Who can act as a Health Supervisor at a camp?

A Maryland licensed physician (MD), certified registered nurse practitioner (CRNP), and registered nurse (RN) can serve as a Health Supervisor at a youth camp.

2. How does one find a Health Supervisor?

The owner/operator of the day or residential youth camp can do a number of things to attract a Health Supervisor, including advertising in the local newspaper of the area where the camp is operating. In addition, one could search the Maryland Board of Nursing (MBON) web page for a RN known as a case manager/delegating nurse who is authorized to teach the Medication Technician Training Program. RNs who work in school health can frequently serve in the Health Supervisor position. This RN is also authorized to delegate and supervise the Certified Medication Technician (CMT). For a viewing of these RNs, please see the MBON web page at <http://mbon.maryland.gov>, click on Delegation under General on the left side of the screen. The MBON has temporarily removed the delegating RN list but will repost once it has verified the individuals on the list.

3. Is a Health Supervisor required to be on-site at the camp?

The youth camp regulations (COMAR 10.16.07.04) only require a Health Supervisor on-site at camp when 50% or more of the campers have identified

medical problems, as defined in COMAR 10.16.07.02B(18), such as asthma, cancer, diabetes, or epilepsy. Otherwise, a camp Health Supervisor must be available for consultation at all times when campers are present at camp. When the Health Supervisor is available for consultation and not on-site at the camp, the Department recommends that the Health Supervisor train camp staff members and volunteers during orientation. In addition, the Department recommends that the Health Supervisor, who is not on-site, (and instead consulting and delegating) performs an on-site visit at the beginning of camp to determine if the camp staff members and volunteers are knowledgeable and are implementing the approved health procedures appropriately.

If the Health Supervisor is a CRNP or RN, the CRNP or RN may only delegate medication administration to a competent person with the certification listed in B2. Therefore, the CRNP or RN must do an on-site visit at the beginning of camp to ensure competency of camp staff members and volunteers that are performing delegated nursing activities.

B. Administering Medications in a Youth Camp

1. Do both day and residential youth camps need trained staff to administer medication?

If the day or residential camp is going to administer medications to campers, then yes, the camp must have trained staff at camp to administer medication.

2. Who can administer medication in a camp setting?

A Maryland licensed professional whose scope of practice includes medication administration, may administer medication in a camp setting. A

Maryland licensed health professional may include a Physician (MD), Certified Registered Nurse Practitioner (CRNP), registered nurse (RN), and licensed practical nurse (LPN). In addition, the RN, as the case manager, can also delegate and supervise medication administration to the Certified Medication Technician (CMT) and the Certified Medicine Aide (CMA). Also, an adult staff member or volunteer who is designated by the operator and on an annual basis successfully completes a training course approved annually by the Department may administer routine medication other than insulin.

3. Who is allowed to administer insulin at a camp?

Insulin may only be administered by a licensed or certified professional who is authorized to practice in Maryland and whose scope of practice includes medication administration.

4. What is the difference between the CMT and the CMA?

A Certified Medication Technician (CMT) is defined as an individual who completes a Maryland Board of Nursing (MBON) approved Medication Administration Training Program which is twenty (20) hours in length and who is certified by the MBON as a medication technician. An individual is not required to be a Certified Nursing Assistant (CAN) to become a Certified Medication Technician. The CMT can administer selected medications to individuals in the community based setting; including day and residential youth camps, when:

- A) A RN has delegated this function; and,
- B) The RN is available to supervise, instruct, and evaluate the CMT's performance.

The certified medicine aide (CMA) is an individual who is a CAN; has completed a MBON approved medicine aide-training program; and is certified as a CMA by the MBON. The individual wanting to be trained as a CMA must be certified as a CAN, hold the additional certification of GNA, have specific work experience, and have the recommendation of the Director of Nursing to attend the MBON approved 60-hour medicine aide training program.

5. How do I verify that a new or potential employee is a CMT or CMA?

An individual's status as a CMT or CMA can be verified by utilizing the MBON's web page at <http://mbon.maryland.gov>. To verify the status of an individual CMT, CMA or CNA, go to the web page and then click on License tab at the top. Click "Look Up a License". Scroll down and click "Proceed to look up your license / certification". Enter the individual's first and last name or license number. Click search.

6. How do I verify that staff member or volunteer has taken a medication administration course approved by the Department and is currently certified to administer medication at camp?

The individual, upon successful completion of a medication administration course approved by the Department, can apply to the Department to receive a Youth Camp Medication Administration Certification Card. The card will be valid for 1 year from the date the individual successfully completed the approved course. The card will also list the expiration date. An application to apply for a Youth Camp Medication Administration Certification Card is available on the Department's website under "Most Requested Forms and Documents," by

emailing Euther Steele at euther.steele@maryland.gov or by calling the CHHCS office at 410-767-8417.

7. How does a medication administration course become approved by the Department?

An application to apply for Departmental approval of a medication administration course is available on the Department's website under "Most Requested Forms and Documents," by emailing Euther Steele at euther.steele@maryland.gov or by calling the CHHCS office at 410-767-8417.

8. Is there a list of currently approved courses and instructors?

Yes, the Department has posted a list of approved courses on the Department's website under "Most Requested Forms and Documents". The list can also be obtained by emailing Euther Steele at euther.steele@maryland.gov or by calling the CHHCS office at 410-767-8417.

9. Can a LPN or EMT/Paramedic administer medication or delegate medication administration to a CMT or CMA?

The LPN may administer medications in the camp setting. However, the LPN may not delegate or supervise the CMT or CMA to administer medication in the camp setting.

The EMT may not administer medication or delegate medication administration or supervise others in medication administration in a camp. The EMT/paramedic is licensed to provide care in the pre-hospital setting, e.g. an ambulance. The EMT/paramedic is eligible to be trained and certified as a CMT.

10. How many trained staff are necessary to administer medication at a camp?

A camp does not need to require that all of its counselors are certified as a CMT, CMA, or Youth Camp Medication Administration Certification (YCMAC). However, a camp needs to train enough counselors to accommodate unique camp variables including, but not limited to the: Health of the campers (e.g. campers with identified medical problems versus healthy children); Number of campers at camp; Length of time campers participate at camp (e.g. before and after camp programs or residential camp); Number of camp sessions (e.g. 5 days or 2 weeks); Camp activities (e.g. indoor or outdoor activities, on-site or off-site activities); and Size, geographically, of the camp (e.g. all campers are in one community center for 4 hours a day versus a 10 acre camp with physical outdoor activities such as hiking). The Health Supervisor should help to determine the number of trained staff members or volunteers necessary to administer medication at camp.

C. Self-Administration of Medication

1. What is self-administration of medication?

Self-administration of medication is when an individual is cognitively capable, has the ability to read, and has also developed the maturity necessary to be responsible for taking his or her own medication. Self-administration of medication includes the ability to read the pharmacy dispensed medication container, prepare the right medication for self consumption by selecting the right amount of medication at the right time to be taken by the right route (e.g. oral, subcutaneous injection etc.) as prescribed by the MD or CRNP.

2. How old must the camper be to self-administer medication?

Whether a child can self administer his/her own medication depends on the age of the child; maturity of the child; how much education and training the child has received in self administration of medication and how much practice the child has had in self administering his/her own medication. Many times children 12 to 13 years of age can read well enough to select the right medication at the right time in the right dose and follow the directions on the medication container label. However, when campers self-administer medication, the camp must provide a responsible adult to observe and supervise the child in doing so.

The Department requires that the parent/guardian and prescriber make the determination as to whether or not a camper can or cannot self-administer medication. To authorize self-administration, both the parent/guardian and prescriber must sign the medication administration authorization form under the self-administration section. When a camper is permitted to self-administer medication, COMAR 10.16.07 requires the supervising adult to document when the dose is taken and that the medication is handled and stored properly.

3. Can a camper self-carry medication?

A camper may only self-carry an emergency medication if both the parent/guardian and prescriber have signed the medication administration authorization form consenting for the camper to do so. Self-carry is also only allowed for emergency medication if the camper maintains the medication being self-carried in a secure manner. If a camper fails to maintain the medication in a

secure manner the camp operator should provide another alternative that complies with COMAR 10.16.07.

4. How are emergency medications handled at camp?

Unlike routine medication, emergency medication must be readily available to the camper in case the emergency for which the medication is prescribed presents itself. Therefore, emergency medication should be carried by either the camper needing the medication, if self-carry is authorized; an adult staff member or volunteer directly supervising the camper; or stored at a designated easily accessible location.

5. Who can administer emergency medication at camp?

Emergency medication may be administered by the camper, if self-administration is authorized and the camper is capable of doing so; and adult staff member or volunteer who is licensed or certified to administer medication; or an adult staff member or volunteer trained by the health supervisor.

6. What are standing orders and why are they used?

Standing orders are a prewritten medication order and specific instructions from a licensed or certified prescriber to administer a medication to an individual in clearly defined circumstances.

Camps may use standing orders to be able to provide medications such as Tylenol, Advil, antihistamines, etc. to campers that do not have their own prescriptive order for the medication on file at camp. The camp operator is still required to obtain parental consent before administering any medication in the standing order. A camp operator typically provides a check list of medications

listed in the standing orders for the parent to indicate yes or no to administration for their child.

D. General Questions

1. During a field trip, how are medications administered and handled?

Care should be taken to ensure that medications taken on field trips are handled and stored according to the manufacturer's instructions. The CMT or CMA may not prepare or repackage medication for field trips. Only the Health Supervisor can prepare medications for a field trip.

The Health Supervisor will determine how best to package the camper's medication, where it is to be kept, and what adult will administer the medication or supervise a camper in self-administration. The Health Supervisor must provide specific training to adults accompanying the campers on how best to manage administration of that medication during the trip.

2. Should the camp be concerned about allergic reactions to drugs or food?

Allergic reactions to insects, food, or drugs can be very mild to very severe. The camp, regardless of its purpose, should always be prepared to intervene during an allergic reaction. The Health Supervisor can assist in developing an emergency protocol designed to treat an individual with an allergic reaction. Most campers will have known allergic reactions and should have medical and prescriptive orders for use in the event of an allergic reaction. These orders must be reviewed by the camp's Health Supervisor and kept easily

accessible to camp staff members or volunteers for treatment or in the event of an emergency.

3. Should a camp keep epi pen(s) at camp for use in an emergency?

Allergic reactions to allergens such as food, insect stings, plants, or latex can be very severe. Every camp must be prepared to intervene during an emergency and have a written protocol for severe allergic reactions. The Health Supervisor should assist in developing this protocol. Decisions regarding epi pens are based on specific camp variables discussed in Section B10.

When the camp includes a child or adult with a known history of a severe allergic reaction, the individual will have medical and prescriptive orders for use in the event of an emergency, including their own epi pen prescribed by a physician for use at camp. The orders must be reviewed by the Health Supervisor, kept easily accessible to staff members and volunteers, and the Health Supervisor must train an appropriate number of adult staff members or volunteers at camp on how to administer the epi pen.

4. Who can administer epi pens?

Epi pens are considered an emergency medication and are handled according to Sections B(4) and (5).

5. When a child has asthma, must the asthma inhaler be kept secure in the medication storage area?

Whether a child's inhaler should be kept in the medication storage area, with the adult counselor, or with the child is dependent on whether the inhaler is an emergency or routine medication and whether the child is authorized to self-

carry the medication. If the asthma inhaler is an emergency medication then it is handled according to Sections B(4) and (5). Otherwise, the inhaler is handled as a routine medication.

25 Nurse Licensure Compact (NLC) States

Updated 3/9/2015

COMPACT STATE	IMPLEMENTATION DATE
Arizona	7/1/2002
Arkansas	7/1/2000
Colorado	10/1/2007
Delaware	7/1/2000
Idaho	7/1/2000
Iowa	7/1/2000
Kentucky	6/1/2007
Maine	7/1/2001
Maryland	7/1/1999
Mississippi	7/1/2001
Missouri	6/1/2010
Montana	10/1/2015
Nebraska	1/1/2001
New Hampshire	1/1/2006
New Mexico	1/1/2004
North Carolina	7/1/2000
North Dakota	1/1/2004
Rhode Island	7/1/2008
South Carolina	2/1/2006
South Dakota	1/1/2001
Tennessee	7/1/2003
Texas	1/1/2000
Utah	1/1/2000
Virginia	1/1/2005
Wisconsin	1/1/2000



DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

INTERPRETIVE MEMORANDUM

Date: January 25, 2017

To: MD Youth Camp Operators

From: Joseph T. McKenzie, III, LEHS, REHS/RS, MPH, Chief
Center for Healthy Homes and Community Services

Re: **REVISED POLICY: COMAR 10.16.07.14, Medications (Sunscreen)**

THIS MEMORANDUM SUPERSEDES ALL PREVIOUS INTERPRETIVE MEMORANDA REGARDING SUNSCREEN.

Appropriate sunscreen use is important to prevent skin damage and skin cancer in children. The Department encourages the appropriate use of sunscreen during summer activities. At the same time, sunscreen can cause allergic reactions in a small number of children, and parents may wish to be involved in decisions regarding sunscreen use for their children.

1. The Center for Healthy Homes and Community Services no longer considers sunscreen a medication requiring a prescriptive order.
2. Camps shall obtain authorization from the parent/guardian before applying sunscreen at camp. The authorization shall include the camper's name, the parent or guardian's signature, the date signed, the brand of sunscreen and whether staff may assist the camper in the application of the sunscreen.
3. Camps should encourage parents/guardians to provide sunscreen. Camps are also permitted to provide sunscreen with approval by parents/guardians.
4. Parents/guardians should be encouraged to apply sunscreen to their child before the child attends camp for the day.

This policy is now in effect. Questions may be directed to the Office Help Line toll-free at 1-866-703-3266.

Cc: Claire Pierson, Assistant Attorney General
Sabita Persaud, PhD, RN, APHN-BC, Maryland Board of Nursing

Child's Name: _____

The following information is required:

1st Emergency Contact

(Parent or Legal Guardian): _____ Phone: _____

2nd Emergency Contact

(Other than Parent Above): _____ Phone: _____

Child's Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

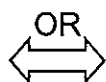
☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For campers who reside **within** the United States, a United States territory, or the District of Columbia:



For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides:

2. Is this child exempt from any immunizations? ☐ NO

☐ YES, List them: _____

1. Country in which child resides:

2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: _____ Date: _____

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

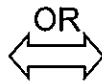
☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐ NO

☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:



For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides:

2. Is this person exempt from any immunizations? ☐ NO

☐ YES, List them: _____

1. Country in which person resides:

2. Attach Department form DHMH-896 (record of vaccination or immunity)

Staff Member/Volunteer Signature or

Date

Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

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CHILD'S NAME _____ LAST _____ FIRST _____ MI _____
 SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____
 COUNTY _____ SCHOOL _____ GRADE _____

PARENT NAME _____ PHONE NO. _____
 OR
 GUARDIAN ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type													
Dose #	DTP-DT _a P-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
 Signature Title Date
 (Medical provider, local health department official, school official, or child care provider only)
 2. _____
 Signature Title Date
 3. _____
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
 Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
 Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

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The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-DHMH ext. 8122

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.
- An authorized individual must bring the medication to the camp and give the medication to an adult staff member.

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ____/____/____ Month Day Year	
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION <input type="checkbox"/> YES -If yes, see Section III below. <input type="checkbox"/> NO	
5. MEDICATION NAME	6. DOSE	7. ROUTE	
8. TIME/FREQUENCY OF ADMINISTRATION		9. IF PRN, FREQUENCY	
10. IF PRN, FOR WHAT SYMPTOMS			
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD			
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is NOT TO EXCEED 1 YEAR.		12a. FROM ____/____/____ Month Day Year	12b. TO ____/____/____ Month Day Year
13. PRESCRIBER'S NAME/TITLE		This space may be used for the Prescriber's Address Stamp	
TELEPHONE	FAX		
ADDRESS			
CITY	STATE		
14a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)			14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an authorized individual, as listed in 15c below, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15c. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. WORK PHONE #

III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	17c. DATE

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-DHMH or 1-877-4MD-8417

KEEP FOR 3 YEARS

MEDICATION FINAL DISPOSITION FORM

for Youth Camps in Maryland

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-DHMH ext. 8417

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I. FINAL DISPOSITION OF MEDICATION	
Child's Name:	Date of Birth:
Medication Name:	Final Disposition: <input type="checkbox"/> Returned (Complete Section A) <input type="checkbox"/> Destroyed (Complete Section B)
Section A	
MEDICATION RETURNED TO (NAME)	DATE
MEDICATION RETURNED BY (PERSON'S SIGNATURE)	DATE
Section B	
The above indicated medication was not retrieved by the parent/guardian or authorized individual within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.07.14.	
SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	DATE
SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	DATE

KEEP FOR 3 YEARS

MARYLAND YOUTH CAMP INCIDENT REPORT FORM

Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608
Phone 410-767-8417 Toll Free 1-877-4MD-DHMH, ext.8417 Fax 410-333-8926

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A. PERSONAL INFORMATION			
1. Name (DO NOT INCLUDE NAME ON COPY SENT TO DHMH)	2. Age	3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Check One <input type="checkbox"/> Day Camper <input type="checkbox"/> Residential Camper <input type="checkbox"/> Camp Employee <input type="checkbox"/> Other:
B. INCIDENT INFORMATION Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.			
5. Report Type (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Medication Error <input type="checkbox"/> Epinephrine	6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset : : <input type="checkbox"/> AM <input type="checkbox"/> PM	
8. Provide short description, do not include names: <div style="text-align: right;"><input type="checkbox"/> Additional information attached</div>			
9. Did the incident require any of the following: AED: <input type="checkbox"/> No <input type="checkbox"/> Yes CPR: <input type="checkbox"/> No <input type="checkbox"/> Yes Epinephrine: <input type="checkbox"/> No <input type="checkbox"/> Yes Inhaler: <input type="checkbox"/> No <input type="checkbox"/> Yes			
10. Was the person transported off-site for medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete A. and B. A. Transported by: <input type="checkbox"/> Camp vehicle <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter B. Treated or evaluated at (check all that apply, specify the name of facility): <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify) _____	11. After off-site or on-site medical evaluation, the person (check all that apply): <input type="checkbox"/> Was admitted to the hospital <input type="checkbox"/> Went home. Date _____ <input type="checkbox"/> Returned to camp with medical restrictions <input type="checkbox"/> Returned to camp with no restrictions 12. Did incident result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes List Date of death: / / List Time of death: : : <input type="checkbox"/> am/ <input type="checkbox"/> pm	13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes 14. Did the incident prompt a report or investigation by government authorities or officials? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) Government Agency _____ Report/Investigation Date _____ Report/Investigation Number _____	
C. INJURY (15 through 22) 15. What caused the injury: (check one, specify below) <input type="checkbox"/> Bite <input type="checkbox"/> Burn <input type="checkbox"/> Contact/collision with <input type="checkbox"/> Person or <input type="checkbox"/> Object <input type="checkbox"/> Drowning <input type="checkbox"/> Near-Drowning <input type="checkbox"/> Fall <input type="checkbox"/> Trip/Slip <input type="checkbox"/> Hazardous Material Exposure <input type="checkbox"/> Poisoning <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify) _____ specify by what _____ 16. Was the injury: <input type="checkbox"/> Unintentional (accidental) <input type="checkbox"/> Intentional (self-inflicted) <input type="checkbox"/> Intentional (inflicted by another) 17. Did the individual sustain a (check all that apply): <input type="checkbox"/> Concussion <input type="checkbox"/> Other Head Injury <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Severe Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> None of above	18. Specify the body part(s) injured: _____ 19. Describe where the injury occurred: <input type="checkbox"/> On Site <input type="checkbox"/> Off Site (specify location) _____ 20. Specify the activity the individual was engaged in at the time of injury (select most applicable activity): <input type="checkbox"/> Archery <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Biking <input type="checkbox"/> Boating (specify) _____ <input type="checkbox"/> Competitive Sport/Game (specify): _____ <input type="checkbox"/> Cooking/Food Preparation <input type="checkbox"/> Fighting <input type="checkbox"/> General Camp Life (specify) _____ <input type="checkbox"/> Groundskeeping/Maintenance (staff only) <input type="checkbox"/> Gymnastics/Dance/Cheerleading <input type="checkbox"/> Horseback Riding		
20. Continued <input type="checkbox"/> Motorized Vehicle (specify) _____ <input type="checkbox"/> Playground <input type="checkbox"/> Primitive Camping <input type="checkbox"/> Rifle <input type="checkbox"/> Rock Climbing/Rappelling <input type="checkbox"/> Ropes Course/Challenge Course/Zip-line <input type="checkbox"/> Swimming <input type="checkbox"/> Walking/Running/Hiking <input type="checkbox"/> Other (specify) _____ 21. Was the activity supervised? <input type="checkbox"/> Not Applicable <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) # of campers in activity _____ # of staff in activity _____ 22. Was the individual using safety equipment? <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes (specify) _____			
D. ILLNESS 23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department. A. Was the illness a suspected reportable disease, condition or outbreak? <input type="checkbox"/> No <input type="checkbox"/> Yes For the required DHMH reportable diseases list and outbreak information go to: http://phpa.dhmmh.maryland.gov/IDEHSharedDocuments/what-to-report/ReportableDisease_HCP.pdf B. Was the illness reported to a local health department? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes (specify department): _____ The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency go to: http://phpa.dhmmh.maryland.gov/IDEHSharedDocuments/what-to-report/DHMH1140.pdf			
E. MEDICATION ERROR 24. Right Patient? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Medication? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Time? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Dose? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Route? <input type="checkbox"/> No <input type="checkbox"/> Yes 25. Type of administration: <input type="checkbox"/> Self-Administration: Was camp staff supervising the self-administration? <input type="checkbox"/> No <input type="checkbox"/> Yes Was medication secured? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Staff administration: Staff person's training level (check one): <input type="checkbox"/> Office of child care (6 hour course) <input type="checkbox"/> Certified Medication Technician <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> CNP			
F. EPINEPHRINE 26. Who administered the epinephrine? Name and Title: _____ 27. Was the epinephrine prescribed to: the individual? <input type="checkbox"/> or the Camp, Epinephrine Certificate Holder? <input type="checkbox"/> No <input type="checkbox"/> Yes 28. Trigger: <input type="checkbox"/> Unknown or <input type="checkbox"/> Known: (specify): _____ 29. Symptoms (check all that apply): <input type="checkbox"/> Skin reaction, <input type="checkbox"/> Feeling of warmth, <input type="checkbox"/> Sensation of a lump in the throat, <input type="checkbox"/> Constriction of the airway, swollen tongue, trouble breathing, <input type="checkbox"/> Rapid pulse, <input type="checkbox"/> Nausea, vomiting or diarrhea, <input type="checkbox"/> Dizziness or fainting			
30. Report Completed By-Employee Name (print) _____ Title _____			
31. Camp Name _____		Address _____ DHMH CAMP ID # _____	
32. Notification	Parent, Guardian, or Emergency Contact was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____ Method _____
	Camp Health Supervisor was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Health Supervisor Name _____ Date _____ Method _____
	DHMH/CHS was notified within 24 hours	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	DHMH Contact Name _____ Date _____ Method _____
33. Employee Signature _____		Date _____ Phone Number _____	

REQUIRED HEALTH REPORTS, COMAR 10.16.07.06

Make Report To:⇨ Type:	Minor's Parent/Guardian	Health Supervisor	DHMH	Health Log or Personal Health Record
Injury or illness that results in death, requires CPR, or admission to a hospital	Immediately	Immediately	Verbally within 24 hours and submit the Report Form* within 1 week	Record same day
Injury that is treated at an off-site medical facility and has a positive diagnosis (See COMAR 10.16.06.25B)	Immediately	Immediately	Submit the Report Form* within 4 weeks of the end of camp	Record same day
Accident with no apparent injury Example: a fall from a horse/equipment or impact from sports equipment. (See COMAR 10.16.06.25C&D)	If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written)	Immediately if Health Supervisor is on duty at camp	No report	Record same day
All other injuries & illnesses	If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written)	No report	No report	Record same day
Reportable conditions or outbreaks per COMAR 10.06.01, see list	Immediately	Immediately	Verbally to DHMH and Local Health Department within 24 hours and submit the Report Form* to DHMH within 1 week.	Record same day
Medication Error or Auto-injectable Epinephrine	Immediately	Immediately	Submit the Report Form* within 4 weeks of the end of camp	Record same day

Maintain documentation of reports at camp.

***Before forwarding reports to DHMH, remove confidential information such as person's name.
DO NOT REMOVE AGE, GENDER OR DATE/TIME OF INCIDENT.**

DHMH, Center for Healthy Homes and Community Services
6 St Paul St, Suite 1301
Baltimore, MD 21202-1608
Phone: 410-767-8417 Fax: 410-333-8926

YOUTH CAMP MEDICATION ADMINISTRATION CERTIFICATE HOLDER APPLICATION

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

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I. APPLICANT			
CAMP APPLICANT NAME		CAMP NAME	CAMP LICENSE NUMBER
APPLICANT'S MAILING ADDRESS		APPLICANT'S WORK PHONE	
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			
II. AGE			
ARE YOU AN ADULT, AS DEFINED IN COMAR 10.16.06 AND 10.16.07?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
III. TRAINING COURSE			
A) HAVE YOU SUCCESSFULLY COMPLETED A MEDICATION ADMINISTRATION COURSE APPROVED BY THE DEPARTMENT?			
<input type="checkbox"/> YES		<input type="checkbox"/> NO	
B) NAME OF APPROVED COURSE			
C) HAVE YOU ATTACHED A COPY OF YOUR COMPLETION CERTIFICATE?			
<input type="checkbox"/> YES		<input type="checkbox"/> NO	
V. APPLICANT'S SIGNATURE			
<p>I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle may result in suspension or revocation of my certificate. <i>If you have questions, please call DHMH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.</i></p>			
X _____		DATE _____	
APPLICANT'S SIGNATURE			
FOR INTERNAL USE ONLY (Do Not Write Below This Line)			
TRACKING #: _____			
<input type="checkbox"/> APPROVED			
<input type="checkbox"/> DENIED Reason: _____			
X _____		DATE _____	
CHHCS CHIEF'S SIGNATURE			

YOUTH CAMP MEDICATION ADMINISTRATION COURSE APPLICATION

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

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I. APPLICANT INFORMATION			
APPLICANT'S NAME			
APPLICANT'S MAILING ADDRESS			APPLICANT'S WORK PHONE
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			
II. BUSINESS INFORMATION			
BUSINESS NAME			
BUSINESS MAILING ADDRESS		CITY	STATE ZIP CODE
NAME OF TRAINING			
III. INSTRUCTOR CREDENTIALS (FOR EACH ADDITIONAL INSTRUCTOR SUBMIT INFORMATION ON ANOTHER SHEET OF PAPER)			
INSTRUCTOR'S NAME			
WHICH LICENSE TYPE DO YOU HOLD?			
<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> REGISTERED NURSE <input type="checkbox"/> CERTIFIED NURSE PRACTITIONER			
LICENSE NUMBER:			
IV. WRITTEN MATERIALS			
SUBMIT COPIES OF THE FOLLOWING FOR REVIEW:			
A) Training manual			
B) All handouts			
B) All presentations			
C) All exams			
D) Certificate issued to student upon completion			
V. APPLICANT'S SIGNATURE			
I have carefully examined and read this application and when teaching, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding routine medication, except for insulin, at youth camps. I understand that providing false information on this application or violating, Maryland Health-General Code Annotated Title 13, Subtitle 7; Title 14, Subtitle 4; or any regulation adopted by the Department under these subtitles may result in suspension or revocation of my course approval. If you have questions, please call DHMH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.			
X		DATE	
APPLICANT'S SIGNATURE			
FOR INTERNAL USE ONLY (Do Not Write Below This Line)			
<input type="checkbox"/> APPROVED		<input type="checkbox"/> DENIED Reason: _____ TRACKING #: _____	
X		DATE	
EHB DIRECTOR'S SIGNATURE			

EMERGENCY EPINEPHRINE CERTIFICATE HOLDER APPLICATION

Department of Health & Mental Hygiene (DHMH) **129**
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. YOUTH CAMP OPERATOR

CAMP OPERATOR NAME		CAMP NAME	CAMP LICENSE NUMBER
OPERATOR'S MAILING ADDRESS		OPERATOR'S WORK PHONE	
CITY	STATE	ZIP CODE	OPERATOR'S CELL PHONE
OPERATOR'S EMAIL			

II. AGE

ARE YOU AT LEAST 18 YEARS OLD? ☐ YES ☐ NO

III. TRAINING COURSE

A) HAVE YOU SUCCESSFULLY COMPLETED AN EMERGENCY EPINEPHRINE EDUCATIONAL TRAINING PROGRAM APPROVED BY THE DEPARTMENT?

☐ YES ☐ NO

B) NAME OF APPROVED TRAINING COURSE

C) HAVE YOU ATTACHED A COPY OF YOUR TRAINING CERTIFICATE? ☐ YES ☐ NO

IV. WRITTEN POLICY

DOES THE ATTACHED COPY OF YOUR WRITTEN POLICY INCLUDE THE FOLLOWING:

- A) Your Designated Agents?
- B) The Name of the Approved Training Program?
- C) Procedures to:
 - 1) Store emergency auto-injectable epinephrine?
 - 2) Notify parent or guardian that emergency auto-injectable epinephrine is available at camp?
 - 3) Maintain the emergency auto-injectable epinephrine in a secure manner?
 - 4) Report the use of emergency auto-injectable epinephrine according to COMAR 10.16.07.06?
 - 5) Train the emergency epinephrine certificate holder and agent(s) annually?
 - 6) Maintain documentation of training for emergency epinephrine certificate holder and agent(s) for 3 years?

V. OPERATOR'S SIGNATURE

I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle may result in suspension or revocation of my certificate. *If you have questions, please call DHMH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.*

X _____ DATE
APPLICANT'S SIGNATURE

FOR INTERNAL USE ONLY (Do Not Write Below This Line)

☐ APPROVED ☐ DENIED Reason: _____ TRACKING #: _____

X _____ DATE
CHHCS CHIEF'S SIGNATURE

EMERGENCY EPINEPHRINE TRAINING PROGRAM APPLICATION

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

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I. APPLICANT INFORMATION			
APPLICANT'S NAME			
APPLICANT'S MAILING ADDRESS			APPLICANT'S WORK PHONE
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			
II. BUSINESS INFORMATION			
BUSINESS NAME			
BUSINESS MAILING ADDRESS		CITY	STATE ZIP CODE
NAME OF TRAINING			
III. INSTRUCTOR CREDENTIALS (FOR EACH ADDITIONAL INSTRUCTOR SUBMIT INFORMATION ON ANOTHER SHEET OF PAPER)			
INSTRUCTOR'S NAME			
WHICH LICENSE TYPE DO YOU HOLD?			
<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> REGISTERED NURSE <input type="checkbox"/> CERTIFIED NURSE PRACTITIONER			
LICENSE NUMBER:			
IV. WRITTEN MATERIALS			
SUBMIT COPIES OF THE FOLLOWING FOR REVIEW:			
A) Training manual, to include all requirements list in COMAR 10.16.07.15D			
B) All handouts			
B) All presentations			
C) All exams			
D) Certificate issued to student upon completion			
V. APPLICANT'S SIGNATURE			
I have carefully examined and read this application and when teaching, agree to comply with all applicable laws and COMAR 10.16.07 of the State of Maryland regarding emergency epinephrine at youth camps. I understand that providing false information on this application or violating, Maryland Health-General Code Annotated Title 13, Subtitle 7; Title 14, Subtitle 4; or any regulation adopted by the Department under these subtitles may result in suspension or revocation of my course approval. <i>If you have questions, please call DHMH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.</i>			
X		DATE	
APPLICANT'S SIGNATURE			
FOR INTERNAL USE ONLY (Do Not Write Below This Line)			
<input type="checkbox"/> APPROVED		<input type="checkbox"/> DENIED Reason: _____ TRACKING #: _____	
X		DATE	
EHB DIRECTOR'S SIGNATURE			

ANNUAL REPORT

The Annual Report is due within 4 weeks of the end of camp. Please enter the report online.
Go to the website: <https://envhlthlicensing.dhmf.maryland.gov/Account/Login>

Start with **Click here to Register**

Create a User Name and Password

You need your Certificate number and your Serial number from your 2017 certificate or letter of compliance. Contact the office if you don't have it.

You will be able to see the status of your license and you can enter your 2017 Annual Report.

Entering information on the report:

- Enter one week of camp per line,
- All dates must be in the mm/dd/yyyy format, such as, 06/19/2017,
- You don't enter the Camper Days because when you use the Calculate button at the bottom, it will do the math for you,
- Please see the chart: Required Health Reports, COMAR 10.16.007.06 for what counts as a 'Reportable' Injury or Illness,
- The current Annual Report has a column for medication errors and epinephrine administration,
- The column # of Epinephrine is if you had to administer an auto-injectable epinephrine, not the number brought to camp.
- If you have any 'Reportable' injuries, illness, or medication errors or epinephrine administration incidents, **do not try to enter the Incident Report on line yet, it is not ready, sorry!**
 - Submit a copy of the Incident Report form, (without the Name on it) separately.
- You must enter the Name, Phone number, and Email of the person completing the report,
- Then Submit!

Youth Camp Safety Advisory Council Annual Report

Maryland Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore, MD 21202-1608
Phone (410) 767-8417 or Toll Free 1-877-4MD-DHMH ext 8417
Fax (410) 333-8926

YEAR: ☐ Revised copy

• At the end of your camping season, please complete the information below and submit the completed form to the Department of Health and Mental Hygiene (DHMH) at the above address or fax number. Maryland Certification for Youth Camps, COMAR 10.16.06.06, requires that an operator files an annual report and any required injury/illness reports **within 4 weeks of the end of camp**.

• If you do not submit an annual report and any required injury/illness reports within 4 weeks of the end of camp, you are in violation of the Certification for Youth Camp Regulations, COMAR 10.16.06.06. According to Certification for Youth Camp Regulations, COMAR 10.16.06.14 this Office may deny your renewal application for failure to submit this annual report and any required injury/illness reports and camp will not be eligible to be in "Good Standing" with the Department and pay the reduced fee.

→ Camp Name _____ Certificate # _____

→ Camp Address: _____ City: _____ State: _____ Zipcode: _____

→ Complete the following chart with the understanding that a camp may operate continuously throughout the season or with breaks in operation (i.e. weekends).

Week	Weekly Operation Dates		# of Days (A)	# of Campers (B)	# of Camper Days (A x B)	# of Reportable Injuries	# of Reportable Diseases/ Conditions	# of Medication Errors	# of Epi-nephrine	# of Fatalities	# of Staff
	Start Date (MM/DD/YY)	End Date (MM/DD/YY)									
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
Please Total These Columns →→→											

If not previously done, submit the required injury/illness report form(s) to DHMH, for each individual involved, with this annual report. In order to maintain confidentiality, remove camper/staff member's name and other personal identifiers from the completed injury/illness report form before submitting.

→ Signature _____ Date _____ Phone # _____

→ Print Name and Title of Person Completing this Form _____

→ Print Email of Person Completing this Form _____

COMPLIANCE SCHEDULE

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

DHH-4766 (1/15)

VARIANCE REQUEST

VARIANCE REQUEST APPLICATION

Department of Health & Mental Hygiene (DHMH) **137**
 Center for Healthy Homes and Community Services (CHHCS)
 6 St. Paul Street, Suite 1301
 Baltimore, Maryland 21202-1608
 (410) 767-8417 FAX (410) 333-8926
 Toll Free 1-877-4MD-DHMH ext. 8417

I. Camp Owner Information		
NAME OF OWNER		
MAILING ADDRESS OF OWNER		
CITY	STATE	ZIP CODE
II. Camp Information		
CAMP NAME		
PHYSICAL ADDRESS		
CITY	STATE	ZIP CODE
TYPE OF FACILITY <input type="checkbox"/> DAY CAMP <input type="checkbox"/> RESIDENTIAL CAMP <input type="checkbox"/> DAY & RESIDENTIAL CAMP <input type="checkbox"/> TRIP CAMP <input type="checkbox"/> TRAVEL CAMP		
III. Variance Request Information		
SPECIFY THE APPLICABLE REGULATION TO WHICH THE VARIANCE REQUEST PERTAINS		
EXPLAIN THE REASON FOR THE VARIANCE REQUEST		
GIVE SPECIFIC DETAILS OF THE PROPOSED ALTERNATIVE PROCEDURE		
IV. Signature		
SIGNATURE OF OWNER OR AUTHORIZED REPRESENTATIVE		DATE
PHONE NUMBER	EMAIL ADDRESS	
For Office Use Only		
IS THE APPLICATION JUSTIFIED DUE TO PHYSICAL LIMITATION OF THE EXISTING LAYOUT OF THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES THE ALTERNATIVE PROCEDURE MEET OR PRODUCE THE INTENDED EFFECT OF THE REGULATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES THE ALTERNATIVE PROCEDURE MAINTAIN THE PROTECTION OF THE HEALTH AND SAFETY OF THE INDIVIDUALS USING THE FACILITY AT OR ABOVE THE LEVEL REQUIRED BY THE REGULATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
COMPLIANCE SCHEDULE IS: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (see above reason)		
ENVIRONMENTAL HEALTH SPECIALIST'S SIGNATURE		DATE

NOTICE TO THE PUBLIC

NON-DISCRIMINATION STATEMENT AND ACCESSIBILITY REQUIREMENTS

The Department of Health and Mental Hygiene (the Department) complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

The Department, upon request:

- Provides free aids and services to people with disabilities to communicate effectively with Department staff, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please contact Environmental Health Bureau directly.

If you believe that the Department has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Delinda Johnson, Equal Access Compliance Unit, Office of Equal Opportunity Programs, Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Room 514, Baltimore, Maryland 21201, 410-767-6600 (voice), 1-800-735-2258 (TTY), (410) 333-5337 (Fax), delinda.johnson@maryland.gov (email).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Delinda Johnson is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

*Help is available in your language: 410-767-8400 (TTY: 1-800-735-2258).
These services are available for free.*

Español/Spanish

Hay ayuda disponible en su idioma: 410-767-8400 (TTY: 1-800-735-2258)). Estos servicios están disponibles gratis.

አማርኛ/Amharic

እገዛ በ ቋንቋዎ ማግኘት ይችላሉ:-: 410-767-8400 (TTY: 1-800-735-2258) ::

እነዚህ አገልግሎቶች ያለከፍያ የሚገኙ ነጻ ናቸው።

العربية /Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 8400-767-410 (رقم هاتف

الصم والبكم: (1-800-735-2258)

中文/Chinese

用您的语言为您提供帮助：410-767-8400 (TTY: 1-800-735-2258)。 这些服务都是免费的

فارسی /Farsi

خط تلفن کمک به زبانی که شما صحبت می کنید : 1-800-735-2258 (خط تماس افراد ناشنوا 1-800-000-0000)

این خدمات به صورت رایگان در دسترس هستند

Français/French

Vous pouvez disposer d'une assistance dans votre langue : 410-767-8400 (TTY: 1-800-735-2258). Ces services sont disponibles pour gratuitement.

ગુજરાતી/Gujarati

તમારી ભાષામાં મદદ ઉપલબ્ધ છે: 410-767-8400 (ટીટીવાય: (TTY: 1-800-735-2258). સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole

Gen èd ki disponib nan lang ou: 410-767-8400 (TTY: 1-800-735-2258). Sèvis sa yo disponib gratis.

Igbo

Enyemaka di na asusu gi: 410-767-8400 (TTY: 1-800-735-2258). Oṣu ndị a dị na enweghi ugwo i ga akwu maka ya.

한국어/Korean

사용하시는 언어로 지원해드립니다: 410-767-8400 (TTY: 1-800-735-2258). 무료로 제공 됩니다

Português/Portuguese

A ajuda está disponível em seu idioma: 410-767-8400 (TTY: 1-800-735-2258). Estes serviços são oferecidos de graça.

Русский/Russian

Помощь доступна на вашем языке: 410-767-8400 (TTY: 1-800-735-2258). Эти услуги предоставляются бесплатно.

Tagalog

Makakakuha kayo ng tulong sa iyong wika: 410-767-8400 (TTY: 1-800-735-2258). Ang mga serbisyong ito ay libre.

اردو/Urdu).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال
410-767-8400 (TTY: 1-800-735-2258) کر

Tiếng Việt/Vietnamese

Hỗ trợ là có sẵn trong ngôn ngữ của quý vị 410-767-8400 (TTY: 1-800-735-2258). Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba

Ìrànṣẹ́ wà ní àrọ̀wọ̀tó ní èdè rẹ: 410-767-8400 (TTY: 1-800-735-2258). Awon ise yi wa fun o free.

DEPARTMENTAL INFORMATION

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PREVENTION AND HEALTH PROMOTION ADMINISTRATION

ENVIRONMENTAL HEALTH BUREAU

OFFICE OF HEALTHY HOMES AND COMMUNITIES

CENTER FOR HEALTHY HOMES AND COMMUNITY SERVICES

6 SAINT PAUL STREET, SUITE 1301

BALTIMORE, MD 21202

PHONE: 410-767-8417

FAX: 410-333-8926

EMAIL:

CENTER SECRETARY: EUTHER.STEELE@MARYLAND.GOV

CENTER CHIEF: TOMMY.MCKENZIE@MARYLAND.GOV